

Medicare

Provider Reimbursement Manual -

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 36, Form CMS-2552-96

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 20

Date: July 2009

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NEW/REVISED MATERIAL--EFFECTIVE DATE:

This transmittal updates Chapter 36, Hospital and Hospital Health Care Complex Cost Report, (Form CMS-2552-96). This transmittal also reflects further clarification to existing instructions and incorporates select Federal Register provisions. The effective date for instructional changes will vary due to various implementation dates.

Pub. 15-2-36

Significant Revisions:

- Worksheet S-2 - Lines 21.06 and 21.07 are revised and added, respectively, to implement section 147 of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 extending transitional outpatient payment (TOPs) for small rural hospitals and sole community hospitals (SCHs) both with 100 or fewer beds.
- Worksheet S-3, Part II - Revised various line instructions to clarify wage index instructions.
- Worksheet S-8, Part II - Lines 9 and 10 are not applicable effective for cost reporting periods ending on or after May 31, 2009.
- Worksheet A - Line 55.01 (implantable devices charged to patients) is added to identify generally high cost implantable medical devices chargeable and traceable to specific patients effective for cost reporting periods beginning on or after May 1, 2009.
- Worksheet D, Part V - Revised line 44 to reflect for CAHs effective for services rendered on or after July 1, 2009, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. See MIPPA 2008, section 148 and CR 6395, transmittal 1729, dated May 8, 2009.
- Worksheet E, Part A - Revised line 5.05 with the updated average cost per dialysis of \$401.43. That is \$133.81 times the average number of treatments (3) per week. This field will now be an input. See CR 6216, transmittal 98, dated December 12, 2008.
 - Revised line 7 to reflect the implementation of MIPPA 2008, section 122 which adds the 2006 base year as an additional comparison amount for determining SCH.
- Worksheet E, Part B - Line 1.06 is revised to reflect the implementation of MIPPA 2008, section 147 extending TOPs for small rural hospitals and SCHs both with 100 or fewer beds. See CR 6320, transmittal 1657, dated December 31, 2008.
 - Worksheet E, Part B - Added outlier reconciliation section (lines 50 through 54) effective for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009.
- Worksheet E-3, Part VI - Revised the instructions to lines 6 and 7 to more appropriately compare the unweighted FTE to the unweighted section 422 cap.
- Worksheet L, Part I - Revised this section to remove the 50 percent reduction (previously implemented in T19) applied to capital IME for fiscal year 2009 in accordance with the American Recovery and Reinvestment Act of 2009 (ARRA 2009), section 4301(b). This gives the provider the full capital IME amount for discharges occurring on or after October 1, 2008 through September 30, 2009. See CR 6444, transmittal 466, dated March 27, 2009.

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods ending on or after May 31, 2009.

DISCLAIMER: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

4. Round to 5 decimal places:
 - a. Sequestration (e.g., 2.092 percent is expressed as .02092)
 - b. Payment reduction (e.g., capital reduction, outpatient cost reduction)
5. Round to 6 decimal places:
 - a. Ratios (e.g., unit cost multipliers, cost/charge ratios, days to days)

Where a difference exists within a column as a result of computing costs using a fraction or decimal, and therefore the sum of the parts do not equal the whole, the highest amount in that column must either be increased or decreased by the difference. If it happens that there are two high numbers equaling the same amount, adjust the first high number from the top of the worksheet for which it applies.

3600.2 Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

A&G	-	Administrative and General
AHSEA	-	Adjusted Hourly Salary Equivalency Amount
<i>ARRA</i>	-	<i>American Recovery and Reinvestment Act of 2009</i>
ASC	-	Ambulatory Surgical Center
BBA	-	Balanced Budget Act
BBRA	-	Balanced Budget Reform Act
BIPA	-	Benefits Improvement and Protection Act
CAH	-	Critical Access Hospitals (10/97)
CAPD	-	Continuous Ambulatory Peritoneal Dialysis
CAP-REL	-	Capital-Related
CBSA	-	Core Based Statistical Areas
CCN	-	CMS Certification Number (formerly known as a provider number)
CCPD	-	Continuous Cycling Peritoneal Dialysis
CCU	-	Coronary Care Unit
CFR	-	Code of Federal Regulations
CMHC	-	Community Mental Health Center
CMS	-	Center for Medicare and Medicaid Services
COL	-	Column
CORF	-	Comprehensive Outpatient Rehabilitation Facility
CRNA	-	Certified Registered Nurse Anesthetist
CTC	-	Certified Transplant Center
DRA	-	Deficit Reduction Act of 2005
DRG	-	Diagnostic Related Group
DSH	-	Disproportionate Share
EACH	-	Essential Access Community Hospital
ESRD	-	End Stage Renal Disease
FQHC	-	Federally Qualified Health Center
FR	-	Federal Register
FTE	-	Full Time Equivalent
GME	-	Graduate Medical Education
HHA	-	Home Health Agency
HMO	-	Health Maintenance Organization
HSR	-	Hospital Specific Rate
I & Rs	-	Interns and Residents
ICF/MR	-	Intermediate Care Facility for the Mentally Retarded (9/96)
ICU	-	Intensive Care Unit
IME	-	Indirect Medical Education
INPT	-	Inpatient
IPF	-	Inpatient Psychiatric Facility
IRF	-	Inpatient Rehabilitation Facility
LIP	-	Low Income Patient

LOS	-	Length of Stay
LCC	-	Lesser of Reasonable Cost or Customary Charges
LTCH	-	Long Term Care Hospital
MA	-	Medicare Advantage (previously known as M+C)
M+C	-	Medicare + Choice (also known as Medicare Part C)
MCP	-	Monthly Capitation Payment
MDH	-	Medicare Dependent Hospital (10/97)
MED-ED	-	Medical Education
<i>MIPPA</i>	-	<i>Medicare Improvements for Patients and Providers Act of 2008</i>
MMA	-	Medicare Prescription Drug Improvement and Modernization Act of 2003
MSA	-	Metropolitan Statistical Area (10/97)
MS-DRG	-	Medicare Severity Diagnosis-Related Group
MSP	-	Medicare Secondary Payer
NF	-	Nursing Facility
NHCMQ	-	Nursing Home Case Mix and Quality Demonstration
NPI	-	National Provider Identifier
OBRA	-	Omnibus Budget Reconciliation Act
OLTC	-	Other Long Term Care
OOT	-	Outpatient Occupational Therapy
OPD	-	Outpatient Department
OPO	-	Organ Procurement Organization
OPPS	-	Outpatient Prospective Payment System
OPT	-	Outpatient Physical Therapy
OSP	-	Outpatient Speech Pathology
ORF	-	Outpatient Rehabilitation Facility
PBP	-	Provider-Based Physician
PPS	-	Prospective Payment System
PRM	-	Provider Reimbursement Manual
PRO	-	Professional Review Organization
PS&R	-	Provider Statistical and Reimbursement System
PT	-	Physical Therapy
RCE	-	Reasonable Compensation Equivalent
RHC	-	Rural Health Clinic
RPCH	-	Rural Primary Care Hospitals
RT	-	Respiratory Therapy
RUG	-	Resource Utilization Group
SCH	-	Sole Community Hospitals
SCHIP	-	State Children Health Insurance Program
SNF	-	Skilled Nursing Facility
SSI	-	Supplemental Security Income
TEFRA	-	Tax Equity and Fiscal Responsibility Act of 1982
<i>TOPS</i>	-	<i>Transitional Outpatient Payment System</i>
UPIN	-	Unique Physician Identification Number
WKST	-	Worksheet

NOTE: In this chapter, TEFRA refers to §1886(b) of the Act and not to the entire Tax Equity and Fiscal Responsibility Act.

3600.3 Instructional, Regulatory and Statutory Effective Dates.--Throughout the Medicare cost report instructions, various effective dates implementing instructions, regulations and/or statutes are utilized.

Where applicable, at the end of select paragraphs and/or sentences the effective date (s) is indicated in parentheses () for cost reporting periods ending on or after that date, i.e., (12/31/01).

Dates followed by a “b” are effective for cost reporting periods beginning on or after the specified date, i.e., (1/1/01b). Dates followed by an “s” are effective for services rendered on or after the specified date, i.e., (4/1/01s). Instructions not followed by an effective date are effective retroactive back to 9/30/96 (transmittal 1).

3601. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-2552-96

Part I - Departmental Cost Adjustments and Cost Allocations

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
1	S-2	Read §3604. Complete entire worksheet.
2	S-3, (Parts I-III)	Read §3605-3605.3. Complete worksheets.
3	S-10	Read §3609.4
4	A	Read §3610. Complete columns 1-3, lines 1-101.
5	A-6	Read §3611. Complete, if applicable.
6	A	Read §3610. Complete columns 4 and 5, lines 1-101.
7	A-7	Read §3612. Complete entire worksheet.
8	A-8-1	Read §3614. Complete Part A. If the answer to Part A is yes, complete Parts B and C.
9	A-8-2	Read §3615. Complete, if applicable.
10	A-8-3	(Parts I-VII) Read §§3616-3616.7. Complete, if applicable.
11	A-8	Read §3613. Complete entire worksheet.
12	A	Read §3610. Complete columns 6 and 7, lines 1-101.
13	B, Part I and B-1	Read §3617. Complete all columns through column 27.
14	B, Parts II and III	Read §3618. Complete worksheets.
15	B-2	Read §3619. Complete, if applicable.
16	L-1, Part I	Read §§3661 and 3661.1. Complete, if applicable.

<u>Step</u>	<u>Worksheet</u>	<u>Instructions</u>
<u>Part II - Departmental Cost Distribution and Cost Apportionment</u>		
1	C, Parts I, II, III, IV, and V	Read §3620-3620.5. Complete all applicable columns of worksheet, lines 25-61 and 63-101.
2	D, Part I	Read §§3621 and 3621.1. Complete entire worksheet.
3	D, Part III	Read §§3621 and 3621.3. Complete entire worksheet.
4	L-1, Part II	Read §3661.2. Complete, if applicable.
5	D-1 (Parts I and IV)	
6	D, Part II	Read §§3621 and 3621.2. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each hospital and subprovider subject to PPS or TEFRA provisions.
7	D, Part IV	Read §§3621 and 3621.4. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each hospital and subprovider subject to PPS or TEFRA provisions.
8	L-1, Part III	Read §3661.3. Complete, if applicable.
9	D, Part V	Read §§3621 and 3621.5. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each applicable provider component.
10	D, Part VI	Read 3621.6. Complete entire worksheet. A separate worksheet must be completed for each applicable health care program for each applicable provider component.

Line 21.06--Effective for services rendered after December 31, 2005, does the hospital qualify for the three year transition of hold harmless payments for small rural hospitals under the prospective payment system for hospital outpatient department services, under DRA, *section 5105 or the extension of this provision under MIPPA, section 147 effective for services rendered from January 1, 2009, through December 31, 2009?* Enter , “Y” for yes or “N” for no. Also see CR 4367, transmittal 877, dated February 24, 2006 and *CR 6320, transmittal 1657, dated December 31, 2008, as applicable.* (1/1/2006s) This response impacts the TOPs calculation on worksheet E, Part B, line 1.06.

Line 21.07--Effective for services rendered from January 1, 2009, through December 31, 2009, does the hospital qualify as a SCH with 100 or fewer beds reimbursed under the prospective payment system for hospital outpatient department services, under MIPPA 147? Enter “Y” for yes or “N” for no. Also see CR 6320, transmittal 1657, dated December 31, 2008. This response impacts the TOPs calculation on worksheet E, Part B, line 1.06. (1/1/2009s)

Line 22--Are you classified as a referral center? Enter "Y" for yes and "N" for no.

Line 23--Does your facility operate a transplant center? If yes, enter the certification dates below.

Line 23.01--If this is a Medicare certified kidney transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.02--If this is a Medicare certified heart transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.03--If this is a Medicare certified liver transplant center, enter the certification date in column 2 and termination date in column 3. Also complete Worksheet D-6.

Line 23.04--If this is a Medicare certified lung transplant center, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 23.05--If Medicare pancreas transplants are performed, enter the more recent date of July 1, 1999 (coverage of pancreas transplants) or the certification dates for kidney transplants and termination date in column 3. Also, complete Worksheet D-6.

Line 23.06--If this is a Medicare certified intestinal transplant center, for services rendered on or after October 1, 2001, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 23.07--If this is a Medicare certified islet transplant center, with an effective date for discharges on or after October 1, 2004, enter the certification date in column 2 and termination date in column 3. Also, complete Worksheet D-6.

Line 24--If this is an organ procurement organization (OPO), enter the OPO number in column 2, the *termination* date in column 3.

Line 24.01--If this is a Medicare transplant center; enter the CCN (provider number) in column 2, the certification date or recertification date (after December 26, 2007) in column 3.

Line 25--Is this a teaching hospital or is your facility affiliated with a teaching hospital and receiving payment for I&R? Enter "Y" for yes and "N" for no.

Line 25.01--Is this a teaching program approved in accordance with CMS Pub. 15-I, chapter 4? Enter "Y" for yes and "N" for no.

Line 25.02--If line 25.01 is yes, was Medicare participation and approved teaching program status in effect during the first month of the cost reporting period? Enter "Y" for yes and complete Worksheet E-3, Part IV or "N" for no and complete Worksheets D, Parts III and IV and D-2, Part II, if applicable.

NOTE: CAHs complete question 30.04 in lieu of questions 25, 25.01, and 25.02

Line 25.03--As a teaching hospital, did you elect cost reimbursement for teaching physicians as defined in CMS Pub. 15-I, §2148? Enter "Y" for yes, "N" for no. If yes, complete Worksheet D-9.

Line 25.04--Are you claiming costs on line 70, column 7, of Worksheet A? Enter "Y" for yes and "N" for no. If yes, complete worksheet D-2, Part I.

Line 25.05--Has your facility's direct GME FTE cap (column 1), or IME FTE cap (column 2), been reduced under 42 CFR 413.79(c)(3) or 42 CFR 412.105(f)(1)(iv)(B)? Enter "Y" for yes and "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3 Part VI.)

Line 25.06--Has your facility received additional direct GME (column 1) resident cap slots or IME (column 2) resident cap slots under 42 CFR 413.79(c)(4) or 42 CFR 412.105(f)(1)(iv)(C)? Enter "Y" for yes and "N" for no in the applicable column. (Impacts Worksheet E, Part A; E-3, Part IV; and E-3, Part VI.)

Line 26--If this is a sole community hospital (SCH), enter the number of periods (0, 1 or 2) within this cost reporting period that SCH status was in effect. Enter the beginning and ending dates of SCH status on line 26.01. Use line 26.02 if more than 1 period is identified for this cost reporting period and enter multiple dates. Note: Worksheet C Part II must be completed for the period not classified as SCH (9/96). Multiple dates are created where there is a break in the date between SCH status, i.e., for calendar year provider SCH status dates are 1/1/00-6/30/00 and 9/1/00-12/31/00.

Line 27--If this hospital has an agreement with CMS under either §1883 or §1913 of the Act for swing beds, enter "Y" for yes in column 1 and indicate the agreement date in column 2 (mm/dd/yyyy).

Line 28--If this facility contains a hospital-based SNF, which has been granted an exemption from the cost limits in accordance with 42 CFR 413.30(e), enter "Y" for yes and "N" for no (not applicable for cost reporting periods beginning on or after July 1, 1998). For cost reporting periods beginning on or after July 1, 1998 are all patients identified as managed care patients or did your facility fail to treat Medicare eligible patients (no utilization). Enter "Y" for yes or "N" for no. If no complete lines 28.01 and 28.02 and Worksheet S-7 (7/98).

Line 28.01--If this facility contains a hospital-based SNF, enter in column 1 the payment transition period of 1 = 25/75, 2 = 50/50, 3 = 75/25; or 100. Enter in columns 2 the wage adjustment factor in effect before October 1, and in column 3 the adjustment in effect on or after October 1. SNFs servicing immune-deficient patients may continue 50/50 blend through September 30, 2001.

Line 28.02--Enter the updated hospital based SNF facility rate supplied by your fiscal intermediary if you have not transitioned to 100 percent SNF PPS payment. Enter in column 2

the classification of the SNF at the end of the cost reporting period, either (1) for urban or (2) for rural. Enter in column 3 the SNF's CBSA code. Where the cost reporting period overlaps October 1, 2005, enter in column 3 the SNF's CBSA code for services rendered prior to October 1, 2005, and enter in column 4 the SNF's CBSA code for services rendered on or after October 1, 2005. For cost reporting periods which begin on or after October 1, 2005, enter in column 4 the SNF's CBSA code. If you are located in a rural area enter your State code as your CBSA or CBSA code, as applicable.

Lines 28.03 through 28.20--A notice published in the August 4, 2003, **Federal Register**, Vol. 68, No. 149 provided for an increase in RUG payments to Hospital based Skilled Nursing Facilities (SNF) for payments on or after October 1, 2003, however, this data is required for cost reporting periods beginning on or after October 1, 2003. Congress expected this increase to be used for direct patient care and related expenses. Subscript line 28 into the following lines: 28.03 - Staffing, 28.04 - Recruitment, 28.05 - Retention of Employees, 28.06 - Training, and 28.07-28.20 - Other. Enter in column 1 the ratio, expressed as a percentage, of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 6, column 3. For each line, indicate in column 2 whether the increased RUG payments received for cost reporting periods beginning on or after October 1, 2003 reflects increases associated with direct patient care and related expenses by responding "Y" for yes. Indicate "N" for no if there was no increase in spending in any of these areas. If the increased spending is in an area not previously identified in areas one through four, identify on the "Other (Specify)" line(s), the cost center(s) description and the corresponding information as indicated above.

Line 29--Is this a rural hospital with a certified SNF which has fewer than 50 beds in the aggregate for both components, using the swing bed optional reimbursement method? Enter "Y" for yes and "N" for no. For CAHs the response is always "N" as the optional reimbursement method is not available to CAHs.

Line 30--If this hospital qualifies as a rural primary care hospital (RPCH) or critical access hospital (CAH), enter "Y" for yes in column 1. Otherwise, enter "N" for no, and skip to line 31. (See 42 CFR 485.606ff.) For cost reporting periods beginning on or after October 1, 1997, the classification of rural primary care hospital is replaced by critical access hospitals (10/1/97b).

Line 30.01--Is this cost reporting period the initial 12-month period for which the facility operated as an RPCH? Enter "Y" for yes and "N" for no. For cost reporting periods beginning on or after October 1, 1997 RPCHs are eliminated and critical access hospitals are established and paid on the basis of reasonable costs. This question does not apply to CAHs (10/1/97b).

Line 30.02--If this facility qualifies as an RPCH/CAH, has it elected the all-inclusive method of payment for outpatient services? Enter "Y" for yes and "N" for no (10/97). For cost reporting periods beginning on or after October 1, 2000 CAHs can elect all inclusive payment for outpatient (10/00). An adjustment for the professional component is still required on Worksheet A-8-2 (10/1/97b).

NOTE: If the facility elected the all-inclusive method for outpatient services, professional component amounts should be excluded from deductible and coinsurance amounts and should not be included on E-1.

Line 30.03--If this facility qualifies as an CAH is it eligible for cost reimbursement for ambulance services (12/21/00s). Enter a "Y" for yes or a "N" for no. If yes, enter in column 2 the date eligibility determination was issued. (See 42 CFR 413.70(b)(5))

Line 30.04--If this facility qualifies as a CAH is it eligible for cost reimbursement for I&R training programs? Enter a "Y" for yes or an "N" for no. If yes, the GME elimination is not made on Worksheet B, Part I, column 26 and the program would be cost reimbursed. Also, if applicable, complete Worksheet D-2, Part II.

Line 31--Is this a rural hospital qualifying for an exception to the certified registered nurse anesthetist (CRNA) fee schedule? (See CFR 412.113(c).) Enter "Y" for yes in column 1. Otherwise, enter "N" for no. If you have a subprovider, subscript this line and respond accordingly (9/96) on line 31.01.

Line 32--If this is an all inclusive rate provider (see instructions in CMS Pub. 15-I, §2208), enter the applicable method in column 2.

Line 33--Is this a new hospital under 42 CFR 412.300 (PPS capital)? Enter "Y" for yes or "N" for no in column 1. If yes for new providers with initial cost reporting periods beginning on or after October 1, 2002, do you elect to be reimbursed at 100 percent Federal capital payment? Enter "Y" for yes or "N" for no in column 2.

Line 34--Is this a new hospital under 42 CFR 413.40 (TEFRA)? Enter "Y" for yes or "N" for no in column 1.

Line 35--Have you established a new subprovider (excluded unit) under 42 CFR 413.40 (P)(f)(1)(I) (TEFRA)? Enter "Y" for yes or "N" for no in column 1. If there is more than one subprovider, subscript this line.

Line 36--Do you elect the fully prospective payment methodology for capital costs? (See 42 CFR 412.340.) (This also includes providers that were previously hold harmless, but are now considered 100 percent fully prospective for purposes of completing Worksheet L, Part I in lieu of Worksheet L, Part II.) Enter "Y" for yes or "N" for no in the applicable columns. (For cost reporting periods beginning on or after October 1, 2001, the response is always "Y", except for new providers under 42 CFR 412.304(c)(2), with initial cost reporting periods beginning on or after October 1, 2002, for which the response maybe "N" for the provider's first 2 years.) Questions 36 and 37 are mutually exclusive.

Line 36.01--Does your facility qualify and receive payments for capital disproportionate share in accordance with 42 CFR 412.320? Enter "Y" for yes and "N" for no. If you are eligible as a result of the Pickle amendment, enter "P" instead of "Y."

NOTE: Questions 37 and 37.01 are not applicable for cost reporting periods beginning on or after October 1, 2008.

Line 37--Do you elect the hold harmless payment methodology for capital costs? (See 42 CFR 412.344.) Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for the third thru tenth cost reporting period of new providers under 42 CRF 412.324(b)(2) certified prior to October 1, 1999. If a new provider's response is "Y", complete Worksheet A, line 90 and Worksheet B, Parts II and III.)

Line 37.01--If you are a hold harmless provider, are you filing on the basis of 100 percent of the Federal rate even though payment on this basis may result in lower payment under the hold harmless blend? Enter "Y" for yes or "N" for no in the applicable columns. (Not applicable for cost reporting periods beginning on or after October 1, 2001, except for the third thru tenth cost reporting periods of new providers under 42 CRF 412.324(b)(2) certified prior to October 1, 1999.)

Line 38--Do you have title XIX inpatient hospital services? Enter "Y" for yes or "N" for no in column 1.

Line 38.01--Is this hospital reimbursed for title XIX through the cost report in full or in part? Enter "Y" for yes or "N" for no in column 1.

Line 38.02--Does the title XIX program reduce capital in accordance with Medicare methodology? Enter "Y" for yes or "N" for no in column 1.

Line 38.03--If all of the nursing facility beds are certified for title XIX, and there are also title XVIII certified beds (dual certified) (9/96), are any of the title XVIII beds occupied by title XIX patients? Enter "Y" for yes and "N" for no. You must complete a separate Worksheet D-1 for title XIX for each level of care.

Line 38.04--Do you operate an ICF/MR facility for purposes of title XIX? Enter "Y" for yes and "N" for no (9/96).

Line 39--Do not use this line.

Line 40--Are there any related organization or home office costs claimed? Enter "Y" for yes or "N" for no. If yes, complete Worksheet A-8-1. If you are claiming home office costs enter in column 2

the home office chain number. If this facility is part of a chain enter the name, home office number, FI/contractor number, street address, post office box (if applicable), the city, state, zip code of the home office on lines 40.01 through 40.03. Also, enter on line 40.01, column 2, the FI/ Contractor Name, who receives the Home Office cost statement and in column 3, the FI/Contractor Number.

Line 41--Are provider based physicians' costs included in Worksheet A? Enter "Y" for yes and "N" for no. If yes, complete Worksheet A-8-2.

Line 42--Are physical therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete A-8-3 and/or A-8-4 for services rendered before and on or after April 10, 1998, respectively (4/98).

Line 42.01--Are occupational therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete parts of Worksheet A-8-4 for services rendered on or after April 10, 1998 (4/98).

Line 42.02--Are speech pathology services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, complete all parts of Worksheet A-8-4 for services rendered on or after April 10, 1998 (4/98).

Line 43--Are respiratory therapy services provided by outside suppliers? Enter "Y" for yes and "N" for no. If yes, you may be required to complete all parts of Worksheet A-8-3 and/or A-8-4 where applicable, for services rendered before and on or after April 10, 1998, respectively (4/98).

Line 44--If you are claiming costs for renal services on Worksheet A, are they inpatient services only? Enter "Y" for yes and "N" for no. If yes, do not complete Worksheet S-5 and the Worksheet I series.

Line 45--Have you changed your cost allocation methodology from the previously filed cost report? Enter "Y" for yes or "N" for no. If yes, enter the approval date in column 2.

Line 45.01--Was there a change in the statistical basis? Enter a "Y" for yes or an "N" for no.

Line 45.02--Was there a change in the order of allocation? Enter a "Y" for yes or an "N" for no.

Line 45.03--Was there a change to the simplified cost finding method? Enter a "Y" for yes and an "N" for no (9/96).

Line 46--If the provider-based SNF participates in the NHCMQ demonstration during this cost reporting period, identify the phase of the demonstration. If the SNF is participating, complete Worksheets S-7 and E-3, Part V. Only facilities in Kansas, Maine, Mississippi, New York, South Dakota, and Texas are eligible to participate in the NHCMQ demonstration.

Lines 47 through 51--If you are a provider (public or non public) that qualifies for an exemption from the application of the lower of cost or charges as provided in 42 CFR 413.13, indicate the component and/or services that qualify for the exemption. Subscript as needed for additional components.

Line 52--Does this hospital claim expenditures for extraordinary circumstances in accordance with 42 CFR 412.348(e)? Enter "Y" for yes and "N" for no. If yes, complete Worksheet L-1.

Line 52.01--If you are a fully prospective or hold harmless provider, are you eligible for the special exception payment pursuant to 42 CFR 412.348(g)? Enter "Y" for yes or "N" for. If yes, complete Worksheet L, Part IV. (10/1/2001)

Line 53--If this is a Medicare dependent hospital (MDH), enter the number of periods within this cost reporting period that MDH status was in effect. Enter the beginning and ending dates of MDH status on line 53.01. Subscript line 53.01 if more than 1 period is identified for this cost reporting period and enter multiple dates (10/97).

Line 54--Enter in the appropriate category your annual malpractice premiums. If malpractice costs are being reported in other than the Administrative and General cost center complete line 54.01, and submit supporting schedules listing the cost centers and the amounts contained therein (10/97).

Line 55--Does your facility qualify for additional prospective payment in accordance with 42 CFR 412.107. Enter "Y" for yes and "N" for no (10/97).

Line 56--Are you claiming ambulance costs? Enter a "Y" for yes or a "N" for no. If yes, enter in column 2, for services rendered on and after October 1, 1997, the ambulance payment per trip limit provided by your intermediary. The per trip rate is updated October 1st of each year. For cost reporting periods which overlap October 1, report the payment rate prior to October 1, on line 56, column 2 and the payment rate applicable for services on October 1 to the end of the cost reporting period on line 56.01. For cost reporting periods beginning October 1st no subscribing is required. If this is your first year of providing and reporting ambulance services, you are not subject to the payment limit, however you are still subject to the fee/cost blend. Enter a "Y" for yes or an "N" for no in column 3 (10/97). For services beginning on or after January 1, 2001 the limit will be changed to a calendar year basis. There is an additional update established by regulation for July 1, 2001. Report your ambulance trip limits (column 2) chronologically, in accordance with your fiscal year. Applicable chronological dates (column 0) should be 1/1/2001, 7/1/2001, 1/1/2002, 4/1/2002 (effective date of blend), 1/1/2003, 1/1/2004, 1/1/2005, and 1/1/2006. For services rendered on or after 4/1/2002, enter in column 4 the gross fee schedule amounts (from the PS&R or your records) for the reporting period. For services on and after 4/1/2002 through 12/31/2005 ambulance services will be subject to a blend until 100 percent fee schedule amount is transitioned on 1/1/2006. For cost reporting periods that straddle 1/1/2006, only report ambulance fee schedule amounts for services rendered before 1/1/2006.

CAHs exempt from the ambulance limits (Worksheet S-2, line 30.03, column 1 equals "Y") complete columns 1 and 2 only. (10/1/97b) If you are eligible for cost reimbursement of ambulance services for the entire cost reporting period complete line 56 only, no subscripts are required. A CAH exempt from the ambulance PPS (Worksheet S-2, line 30.03, column 1 equals "Y") is cost reimbursed and not subject to the fee/cost blend or the ambulance per trip limits.

Do not complete line 56 for cost reporting periods beginning on or after January 1, 2006.

Line 57--Are you claiming nursing and allied health costs? Enter "Y" for yes and "N" for no. If yes you must subscript column 2 of Worksheet D, Parts III and IV to separately identify nursing and allied health (paramedical education) from all other medical education costs (1/1/00s).

Line 58--Are you an Inpatient Rehabilitation Facility (IRF) or do you contain an IRF subprovider? Enter in column 1 "Y" for yes and "N" for no. If you are an IRF or if the hospital complex contains an IRF subprovider, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. Complete only column 2 for cost reporting period beginning on or after January 1, 2002 and before October 1, 2002. The response in column 2 determines the IRF payment system, i.e., a response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All IRFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2002.

Line 58.01--If this facility is an IRF or contains an IRF subprovider (response to line 58, column 1 is "Y" for yes), did the facility train residents in teaching programs **in the most recent cost reporting period ending on or before November 15, 2004?** Enter in column 1 "Y" for yes or "N" for no. Is the facility training residents in new teaching programs in accordance with FR, Vol. 70, No. 156, page 47929 dated August 15, 2005? Enter in column 2 "Y" for yes or "N" for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is "Y", then column 2 must be "N" and vice versa; columns 1 and 2 cannot be "Y" simultaneously, columns 1 and 2 can be "N" simultaneously.) If yes, enter a "1", "2", or "3", respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program's existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program's existence, enter the number "4" in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program's existence, enter the number "5" in column 3.

Line 59--Are you a Long Term Care Hospital (LTCH)? Enter in column 1 "Y" for yes and "N" for no. If you are a LTCH, have you made the election for 100 percent Federal PPS reimbursement? Enter in column 2 "Y" for yes and "N" for no. The election must be made in writing 30 days prior to the start of your cost reporting period. Only complete column 2 for cost reporting period beginning on or after 10/1/2002 and before 10/1/2006. The response in column 2 determines the LTCH payment system, i.e., a response of "N" indicates the payment system as "T" for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of "Y" indicates the payment system as "P" for PPS and follows the PPS calculation. All LTCHs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 10/1/2006. LTCHs can only exist as independent /freestanding facilities.

Line 60--Are you an Inpatient Psychiatric Facility (IPF) or do you contain an IPF subprovider? Enter in column 1 "Y" for yes and "N" for no. If you are a IPF or if the hospital complex contains an IPF subprovider, is this a new facility in accordance with CR 3752 (dated 3/4/2005)? Enter in column 2 "Y" for yes and "N" for no. Only complete column 2 for cost reporting period

beginning on or after 1/1/2005 and before 1/1/2008. The response in column 2 determines the IPF payment blend during the transition, i.e., a response of “Y” indicates a new provider that will be paid at 100% of the PPS amount. A response of “N” indicates the payment system as “T” for TEFRA or TEFRA BLEND and follows the TEFRA calculation while a response of “Y” indicates the payment system as “P” for PPS and follows the PPS calculation. All IPFs will be reimbursed at 100 percent Federal PPS for cost reporting periods beginning on or after 1/1/2008.

Line 60.01--If this facility is an IPF or is an IPF subprovider, were residents training in this facility **in the most recent cost report filed before November 15, 2004**? Enter in column 1 “Y” for yes or “N” for no. Is the facility training residents in new teaching programs in accordance with §412.424(d)(1)(iii)? Enter in column 2 “Y” for yes or “N” for no. (Note: questions 1 and 2 must have opposite answers, i.e., if column 1 is “Y”, then column 2 must be “N” and vice versa; columns 1 and 2 cannot be “Y” simultaneously, columns 1 and 2 can be “N” simultaneously.) If yes, enter a “1”, “2”, or “3”, respectively, in column 3 to correspond to the I&R academic year in the first 3 program years of the first new program’s existence that begins during the current cost reporting period. If the current cost reporting period covers the beginning of the fourth academic year of the first new teaching program’s existence, enter the number “4” in column 3. If the current cost reporting period covers the beginning of the fifth or subsequent academic years of the first new teaching program’s existence, enter the number “5” in column 3.

Line 61--Is the hospital part of a multi-campus *hospital that has one or more campuses in different CBSAs*? Enter “Y” for yes, “N” for no. (4/30/2008)

Line 62--If you responded “Y” to question 61, enter information for each campus (including the main campus) as follows: name in column 0, county in column 1, State in column 2, zip code in column 3, CBSA in column 4, and the FTE count for this campus in column 5. If additional campuses exist, subscript this line as necessary. (4/30/2008)

Line 63--Was this cost report filed using the PS&R (either in its entirety or for total charges and days only)? Enter “Y” for yes or “N” for no in column 1. If “Y”, enter the “paid through” date in column 2 (mm/dd/yyyy).

from line 1. For columns 7 - 11, enter the total for each from your records.

Line 13--Enter the number of outpatient visits for cost reporting periods beginning prior to October 1, 1997, for a rural primary care hospital by program and total. An outpatient RPCH visit is defined in 42 CFR 413.70(b)(3)(iii). Begin reporting visits for CAHs for cost reporting periods beginning on or after October 1, 2000.

Line 14--If you have more than one subprovider, subscript this line.

Line 15--If your State recognizes one level of care, complete this line for titles V, XVIII, and XIX.

Do not complete line 16. If you answered yes to line 38.03 of Worksheet S-2, complete all columns. **Exclude NHCMQ days in column 4.**

Line 16--Enter nursing facility days if you have a separately certified nursing facility for Title XIX or you answered yes to line 38.03 of Worksheet S-2. Make no entry if your State recognizes only SNF level of care. If you operate an ICF/MR, subscript this line to 16.01 and enter the ICF/MR days. Do not report any nursing facility data on line 16.01 (9/96).

Line 17--If you have more than one hospital-based other long term care facility, subscript this line.

Line 18--If you have more than one hospital-based HHA, subscript this line.

Line 19--Do not use this line.

Line 20--Enter data for an ASC. If you have more than one ASC, subscript this line.

Line 21--Enter days applicable to hospice patients in a distinct part hospice.

Line 22--Do not use this line.

Line 23--Enter data for the outpatient rehabilitation providers. For reporting of multiple facilities follow the same format used on Worksheet S-2, line 15 (9/96). For CMHCs for services rendered on or after August 1, 2000, enter the number of partial hospitalization days (10/00).

Line 24--Enter the number of outpatient visits for FQHC and RHC. If you have both or multiples of one, subscript the line.

Line 26--Enter the total observation bed days in column 6. Subscript this line for the subprovider (9/96) when both providers are claiming observation bed costs. Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the cost of observation beds since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation bed area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed.

Effective for cost reporting periods beginning on or after October 1, 2004, for line 26 add (unshade) column 5 (total Medicaid observation bed days), subscript column 5 by adding column 5.01 (Medicaid observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission), and column 5.02 (Medicaid observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge).

Additionally, subscript column 6 by adding column 6.01 (Total observation bed days for patients who are subsequently admitted as inpatients but only the hours up to the time of admission) and column 6.02 (Total observation bed days for patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge). The amount in column 5 must equal the sum of columns 5.01 and 5.02 and the amount in column 6 must equal the sum of columns 6.01 and 6.02. (10/1/2004b)

Line 27--Enter in column 4 the number of ambulance trips, as defined by section 4531(a)(1) of The BBA, provided for Medicare patients for ambulance services on or after October 1, 1997. For cost reporting periods that overlap October 1 and July 1, 2001 see §3604, line 56 for proper subscripting (10/97). Effective for services rendered on or after December 21, 2000, ambulance costs for a CAH are reimbursed on costs if Worksheet S-2, column 1, line 30.03 is answered yes. If yes, separate the trips in accordance with Worksheet S-2, line 56 and subscripts. For cost reporting periods that overlap January 1, 2006, subscript line 27 reporting the number of trips prior to January 1, 2006 on line 27 and the number of trips occurring on or after January 1, 2006 on line 27.01. Do not subscript this line for cost reporting periods beginning on or after January 1, 2006, but report all ambulance trips on this line.

Line 28--Enter in column 6 the employee discount days if applicable. These days are used on Worksheet E, Part A, line 4.01 (DSH), Worksheet L, line 4 (capital IME), and Worksheet E-3, Part I, line 1.04 (LIP). Subscript this line for IRF subproviders to capture Employee discount days in column 6. (1/1/02b)

3605.2 Part II - Hospital Wage Index Information--This worksheet provides for the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts of the prospective payment system. It is important for hospitals to ensure that the data reported on Worksheet S-3, Parts II and III are accurate. Beginning October 1, 1993, the wage index must be updated annually. (See §1886(d)(3)(E) of the Act.) Congress also indicated that any revised wage index must exclude data for wages incurred in furnishing SNF services. Complete this worksheet for IPPS hospitals (see §1886(d)), any hospital with an IPPS subprovider, or any hospital that would be subject to IPPS if not granted a waiver.

NOTE: Any line reference for Worksheets A and A-6 includes all subscripts of that line.

Column 1

Line 1--Enter from Worksheet A, column 1, line 101, the wages and salaries paid to hospital employees increased by amounts paid for vacation, holiday, sick, *other* paid-time-off (*PTO*), severance, and bonus pay if not reported in column 1.

NOTE: Bonus pay includes award pay and vacation, holiday, and sick pay conversion (pay in lieu of time off).

NOTE: *Capital related salaries, hours, and wage-related costs associated with lines 1 through 4 of Worksheet A must be excluded from Worksheet S-3, Parts II and III.*

NOTE: *Methodology for including vacation/sick/other PTO accruals in the wage index:*

PTO salary cost -- The required source for costs on Worksheet A is the general ledger (see Provider Reimbursement Manual, Part II, section 3610 and 42 CFR 413.24(e)). Worksheet S-3, Part II (wage index) data are derived from Worksheet A; therefore, the proper source for costs for the wage index is also the general ledger. A hospital's current year general ledger includes both costs that are paid during the current year and costs that are expensed in the current year but paid in the subsequent

year (current year accruals). Hospitals and FIs/MACs are to include on Worksheet S-3, Part II the current year PTO cost incurred as reflected on the general ledger; that is, both the current year PTO cost paid and the current year PTO accrual. (Costs that are expensed in the prior year but paid in the current year (prior year accruals) are not included on a hospital's current year General Ledger and should not be included on the hospital's current year Worksheet S-3, Part II.)

PTO hours -- The source for PTO paid hours on Worksheet S-3, Part II is the payroll report. Hours are included on the payroll report in the period in which the associated PTO expense is paid. Hospitals and FIs/MACs are to include on Worksheet S-3, Part II the PTO hours that are reflected on the current year payroll report, which includes hours associated with PTO cost that was expensed in the prior year but paid in the current year. The time period must cover the weeks that best matches the provider's cost reporting period. (Hours associated with PTO cost expensed in the current year but not paid until the subsequent year (current year PTO accrual) are not included on the current year payroll report and should not be included on the hospital's current year Worksheet S-3, Part II.)

Although this methodology does not provide a perfect match between paid PTO cost and paid PTO hours for a given year, it should approximate an actual match between cost and hours. Over time, any variances should be minimum.

Lines 2 through 8.01--The amounts to be reported must be adjusted for vacation, holiday, sick, *other* paid time off, severance, and bonus pay if not already included. Do not include in lines 2 through 6 the salaries for employees associated with excluded areas lines 8 and 8.01 (10/97).

Line 2--Enter the salaries for directly-employed Part A non-physician anesthetist salaries (for rural hospitals that have been granted CRNA pass through) to the extent these salaries are included in line 1. Add to this amount the costs for CRNA Part A services furnished under contract to the extent hours can be accurately determined. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 8 and 8.01. Additionally, contract CRNA cost must be included on line 9. Report in column 4 the hours that are associated with the costs in column 3 for directly employed and contract Part A CRNAs (10/97).

Do not include *physician assistants*, clinical nurse specialists, nurse practitioners, and nurse midwives. (10/00).

Line 3--Enter the non-physician anesthetist salaries included in line 1, subject to the fee schedule and paid under Part B by the carrier. Do not include salary costs for *physician assistants*, clinical nurse specialists, nurse practitioners, and nurse midwives. (10/99).

Line 4--Enter the physician Part A salaries, (excluding teaching physician salaries), which are included in line 1. Also do not include intern and resident (I & R) salary on this line. Report I & R salary on line 6. Subscript this line to 4.01 and report teaching physicians salaries, Part A included in line 1 above (10/97).

Line 5--Enter the total physician, physician assistant, nurse practitioner and clinical nurse specialist salaries billed under Part B that are included in line 1 (10/99). Under Medicare, these services are related to patient care and billed separately under Part B. Also include physician salaries for patient care services reported for rural health clinics and Federally qualified health clinics included on Worksheet A, column 1, line 63. Report on line 5.01 the non-physician salaries reported for Hospital-based RHC and FQHC services included on Worksheet A, column 1, line 63 (10/99).

Line 6--For Cost reporting periods beginning before October 1, 2000, enter from Worksheet A the salaries reported in column 1 of line 22 for interns and residents. Add to this amount the costs for intern and resident services furnished under contract. For cost reporting periods beginning on or after October 1, 2000, do not report contract *interns and residents* services on line 6; *instead* report contract services on line 6.01 only. Report only the personnel costs associated with these contracts. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items. DO NOT include costs applicable to excluded areas reported on lines 8 and 8.01. Additionally, contract intern and resident costs must be included on line 9. DO NOT include contract intern and residents costs on line 10. Report in column 4 the hours that are associated with the costs in column 3 for directly employed and contract interns and residents.

Line 7--If you are a member of a chain or other related organization as defined in CMS Pub 15-I, §2150, enter, from your records, the wages and salaries for home office related organization personnel that are included in line 1.

Lines 8 and 8.01--Enter the amount reported on Worksheet A, column 1 for line 34 for the SNF. On line 8.01, enter from Worksheet A, column 1, the sum of lines 21, 24, 31, 35, 35.01, 36, 64, 65, 68 through 71, 82 through 86, 89, 92 through 94, and 96 through 100 (10/00). DO NOT include on lines 8 and 8.01 any salaries for general service personnel (e.g., housekeeping) which, on Worksheet A, Column 1, may have been included directly in the SNF and the other cost centers detailed in the instructions for line 8.01.

Line 9--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care, and top level management services as defined below. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (*non-labor costs*). Do not include costs applicable to excluded areas reported on line 8 and 8.01. Include costs for contract CRNA and intern and resident services (these costs are also to be reported on lines 2 and 6 respectively). For cost reporting periods beginning before October 1, 2000, DO NOT include costs for pharmacy and laboratory services furnished under contract and subscript this line to report these costs on line 9.01 and 9.02 respectively (10/97). For cost reporting periods beginning on or after October 1, 2000, DO NOT use lines 9.01 and 9.02, but include on line 9 contract pharmacy and laboratory wage costs as defined below in lines 9.01 and 9.02.

In general, for contract labor, the minimum requirement for supporting documentation is the contract itself. If the wage costs, hours, and non-labor costs are not clearly specified in the contract, then other documentation are necessary, such as a representative sample of invoices which specify the wage costs, hours, and non-labor costs or a signed declaration from the vendor in conjunction with a sample of invoices. Hospitals must be able to provide such documentation when requested by the fiscal intermediary or MAC. A hospital's failure to provide adequate supporting documentation may result in the cost being disallowed for the wage index.

Direct patient care services include nursing, diagnostic, therapeutic, and rehabilitative services. Report only personnel costs associated with these contracts. DO NOT apply the guidelines for contracted therapy services under §1861(v)(5) of the Act and 42 CFR 413.106. Eliminate all supplies, travel expenses, and other miscellaneous items. Direct patient care contracted labor, for purposes of this worksheet, DOES NOT include the following: services paid under Part B: (e.g., physician clinical services, physician assistant services), management and consultant contracts, billing services, legal and accounting services, clinical psychologist and clinical social worker services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care.

Include the amount paid for **top level management services**, as defined below, furnished under contract rather than by employees. Report only those personnel costs associated with the contract. Eliminate all supplies, travel expenses, and other miscellaneous items. Contract management is limited to the personnel costs for those individuals who are working at the hospital facility in the capacity of chief executive officer, chief operating officer, chief financial officer, or nursing administrator. The titles given to these individuals may vary from the titles indicated above. However, the individual should be performing those duties customarily given these positions.

For purposes of this worksheet, contract top level management services DO NOT include the following: other management or administrative services (to be included on lines 9.03 or 22.01; see instructions), physician Part A services, consultative services, clerical and billing services, legal and accounting services, unmet physician guarantees, physician services, planning contracts, independent financial audits, or any services other than the top level management contracts listed above. Per instructions on Form CMS-339, for direct patient care, pharmacy and laboratory contracts, *submit to your Medicare contractor* the types of services, wages, and associated hours; for top level management contracts, *submit* the aggregate wages and hours (10/00).

If you have no contracts for direct patient care or management services as defined above, enter a zero in column 1. If you are unable to accurately determine the number of hours associated with contracted labor, enter a zero in column 1.

For cost reporting periods beginning on or after October 1, 2000, lines 9.01 and 9.02 are no longer required.

Line 9.01--Enter the amount paid for **pharmacy services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit to your fiscal intermediary the following for direct patient care pharmacy contracts: the types of services, wages, and associated hours (10/97).

Line 9.02--Enter the amount paid for **laboratory services** furnished under contract, rather than by employees. DO NOT include the following services paid under Part B (e.g., physician clinical services, physician assistant services), management and consultant contracts, clerical and billing services, legal and accounting services, housekeeping services, security personnel, planning contracts, independent financial audits, or any other service not directly related to patient care. Report only personnel costs associated with the contracts. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. Per instructions on Form CMS-339, submit to your fiscal intermediary the following for direct patient care laboratory contracts: the types of services, wages, and associated hours (10/97).

Line 9.03--Enter the amount paid for **management and administrative services** furnished under contract, rather than by employees. Include on this line contract management and administrative services associated with cost centers other than those listed on lines 21 through 35 (and their subscripts) of this worksheet that are included in the wage index.

Examples of contract management and administrative services that would be reported on line 9.03 include department directors, administrators, managers, ward clerks, and medical secretaries. Report only those personnel costs associated with the *contract*. DO NOT include on

line 9.03 any contract labor costs associated with lines 21 through 35 and subscripts for these lines. DO NOT include the costs for contract top level management: chief executive officer, chief operating officer, and nurse administrator; these services are included on line 9. DO NOT include costs for equipment, supplies, travel expenses, or other miscellaneous items. (10/1/2003b).

Line 10--Enter from your records the amount paid under contract (as defined on line 9) for Part A physician services, excluding teaching physician services. Subscript this line and report Part A teaching physicians under contract on line 10.01. DO NOT include contract I & R services (to be included on line 6) (10/97). DO NOT include the costs for Part A physician services from the home office allocation and/or from related organizations (to be reported on line 12). Also, DO NOT include Part A physician contracts for any of the management positions reported on line 9.

Line 11--Enter the salaries and wage-related costs (as defined on lines 13 and 14) paid to personnel who are affiliated with a home office and/or related organization, who provide services to the hospital, and whose salaries are not included on Worksheet A, column 1. In addition, add the home office/related organization salaries included on line 7 and the associated wage-related costs. This figure must be based on recognized methods of allocating an individual's home office/related organization salary to the hospital. If no home office/related organization exists or if you cannot accurately determine the hours associated with the home office/related organization salaries that are allocated to the hospital, then enter a zero in column 1. All costs for any related organization must be shown as the cost to the related organization.

NOTE: Do not include any costs for Part A physician services from the home office allocation and/or related organizations. These amounts are reported on line 12.

If a wage related cost associated with the home office is not "core" (as described in Part I of Exhibit 6 of the Form-CMS -339) and is not a category included in "other" wage related costs on line 14 (see Part II of Exhibit 6 of Form CMS-339 and line 14 instructions below), the cost cannot be included on line 11. For example, if a hospital's employee parking cost does not meet the criteria for inclusion as a wage-related cost on line 14, any parking cost associated with home office staff cannot be included on line 11 (10/97).

Line 12--Enter from your records the salaries and wage-related costs for Part A physician services, excluding teaching physician Part A services from the home office allocation and/or related organizations. Subscript this line and report separately on line 12.01 the salaries and wage-related costs for Part A teaching physicians from the home office allocation and/or related organizations (10/97).

Lines 13 through 20--In general, the amount reported for wage-related costs must meet the "reasonable cost" provisions of Medicare. For example, in developing pension and deferred compensation costs, hospitals must comply with the requirements in 42 CFR 413.100 and the PRM, Part I, §§ 2140, 2141 and 2142 (see discussion in 70 FR 47369, August 12, 2005).

For those wage-related costs that are not covered by Medicare reasonable cost principles, a hospital shall use generally accepted accounting principles (GAAP). For example, for purposes of the wage index, disability insurance cost should be developed using GAAP. Hospital are required to complete Form CMS-339, Exhibit 6, section III, a reconciliation worksheet to aid hospital and intermediaries in implementing GAAP when developing wage-related costs. Upon request by the intermediary or CMS, hospitals must provide a copy of the GAAP pronouncement, or other documentation, showing that the reporting practice is widely accepted in the hospital industry and/or related field as support for the methodology used to develop the

wage-related costs. If a hospital does not complete Form CMS-339, exhibit 6 section 3, or, the hospital is unable, when requested, to provide a copy of the standard used in developing the wage-related costs, the intermediary may remove the cost from the hospital's Worksheet S-3 due to insufficient documentation to substantiate the wage-related cost relevant to GAAP. (4/30/2008)

NOTE: All costs for any related organization must be shown as the cost to the related organization. (For Medicare cost reporting principles, see PRM 15-I, §1000. For GAAP, see FASB 57.) If a hospital's consolidation methodology is not in accordance with GAAP or if there are any amounts in the methodology that cannot be verified by the intermediary, the intermediary may apply the hospital's cost to charge ratio to reduce the related party expenses to cost.

NOTE: *All wage-related costs, including FICA, workers compensation, and unemployment compensation taxes, associated with physician services are to be allocated according to the services provided; that is, those taxes and other wage-related costs attributable to Part A administrative services must be placed on Line 18, Part A teaching services on Line 18.01, and Part B (patient care services) on Line 19. Line 13 must not include wage-related costs that are associated with physician services.*

Line 13--Enter the core wage-related costs as described in Exhibit 6 of Form CMS-339. (See note below for costs that are not to be included on line 13). Only the wage-related costs reported on Part I of Exhibit 6 are reported on this line. (Wage-related costs are reported in column 2, not column 1, of Worksheet A.)

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 8 and 8.01. Instead, these costs are reported on line 15. Also, do not include the wage-related costs for physicians Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel. (See lines 11, 12, and 16 through 20.)

Health Insurance and Health-Related Wage Related Costs:

For cost reporting periods beginning on or after October 1, 1998, hospitals and fiscal intermediaries are not required to remove from domestic claims costs the personnel costs associated with hospital staff who deliver services to employees. Additionally, health related costs, that is, costs for employee physicals and inpatient and outpatient services that are not covered by health insurance but provided to employees at no cost or at a discount, are to be included as a core wage related cost. The 1 percent test does not apply to health related costs for periods beginning on or after October 1, 1998.

Line 14--Enter the wage-related costs that are considered an exception to the core list. (See note below for costs that are not to be included on line 14.) A detailed list of each additional wage-related cost must be shown on Exhibit 6, Part II of Form CMS-339. In order for a wage-related cost to be considered an exception, it must meet all of the following tests:

- a. The cost is not listed on Exhibit 6, Part I of Form CMS-339,
- b. The wage-related cost has not been furnished for the convenience of the provider,
- c. The wage-related cost is a fringe benefit as defined by the Internal Revenue Service and, where required, has been reported as wages to IRS (e.g., the unrecovered cost of employee meals, education costs, auto allowances), and

- d. The total cost of the particular wage-related cost for employees whose services are paid under IPPS exceeds 1 percent of total salaries after the direct excluded salaries are removed (Worksheet S-3, Part III, column 3, line 3). Wage-related cost exceptions to the core list are not to include those wage-related costs that are required to be reported to the Internal Revenue Service as salary or wages (i.e., loan forgiveness, sick pay accruals). Include these costs in total salaries reported on line 1 of this worksheet.

NOTE: Do not include wage-related costs applicable to the excluded areas reported on lines 8 and 8.01. Instead, these costs are reported on line 15. Also, do not include the wage-related costs for physician Parts A and B, non-physician anesthetists Parts A and B, interns and residents in approved programs, and home office personnel.

Line 15--Enter the total (core and other) wage-related costs applicable to the excluded areas reported on lines 8 and 8.01.

Lines 16 through 20--Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage related costs plus the other wage-related costs. Do not include wage-related costs for excluded areas reported on line 15. Do not include the wage related costs for Part A teaching physicians on line 18. These costs are reported separately on line 18.01 (10/97). On line 19, do not include wage-related costs related to non-physician salaries reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63. These wage-related costs are reported separately on line 19.01 (10/99).

Lines 21 through 35--Enter the direct wages and salaries from Worksheet A column 1 for the appropriate cost center identified on lines 21 through 35, respectively, increased by the amounts paid for vacation, holiday, sick, and paid-time-off if not reported in column 1 of these lines. These lines provide for the collection of hospital wage data for overhead costs to properly allocate the salary portion of the overhead costs to the appropriate service areas for excluded units. These lines are completed by all hospitals if the ratio of Part II, column 4, sum of lines 8 and 8.01 divided by the result of column 4, line 1 minus the sum of lines 2, 3, 4.01, 5, **5.01**, 6, 6.01, and 7 equals or exceeds a threshold of 15 percent. However, all hospitals with a ratio greater than 5 percent must complete line 13 of Part III for all columns. Calculate the percent to two decimal places for purposes of rounding.

Lines 22.01, 26.01, and 27.01--Enter the amount paid for services performed **under contract**, rather than by employees, for administrative and general, housekeeping, and dietary services, respectively. **DO NOT** include costs for equipment, supplies, travel expenses, and other miscellaneous or overhead items. Report only personnel costs associated with these contracts. Continue to report on the standard lines (line 22, 26, and 27), the amounts paid for services rendered by employees not under contract. (10/1/2003b)

Line 22.01--A&G costs are expenses a hospital incurs in carrying out its administrative and/or general management functions. Include on line 22.01 the contract services that are included on Worksheet A, line 6 and subscripts, column 2 ("Administrative and General"). Contract information and data processing services, legal, tax preparation, cost report preparation, and purchasing services are examples of contract labor costs that would be included on Worksheet S-3, Part II, line 22.01. Do not include on line 22.01 the costs for top level management contracts (these costs are reported on line 9). *Do not include on line 22.01 any costs for contract home office personnel (these costs are currently not included in the wage index).*

NOTE: Do not include overhead costs on lines 8 and 8.01.

Column 2--Enter on each line, as appropriate, the **salary** portion of any reclassifications made on Worksheet A-6.

Column 3--Enter on each line the result of column 1 plus or minus column 2.

Column 4--Enter on each line the number of **paid** hours corresponding to the amounts reported in column 3. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours, and hours associated with severance pay. For Part II, lines 1 through 12 (including subscripts), lines 21 through 35 (including subscripts), and Part III, line 13, if the hours cannot be determined, then the associated salaries must not be included in columns 1 through 3 (10/97).

NOTE: The hours must reflect any change reported in column 2. *For employees who work a regular work schedule*, on call hours are not *to be* included in the total paid hours overtime hours are calculated as one hour when an employee is paid time and a half. No hours are required for bonus pay. The intern and resident hours associated with the salaries reported on line 6 must be based on 2080 hours per year for each full time intern and resident employee. The hours reported for salaried employees who are paid a fixed rate are recorded as 40 hours per week or the number of hours in your standard work week (10/97).

NOTE: *For workers who are contracted solely for the purpose of providing services on-call, the wages and associated hours must be included on the appropriate contract labor line on Worksheet S-3.*

Column 5--Enter on all lines (except lines 13 through 20) the average hourly wage resulting from dividing column 3 by column 4.

Column 6--Enter on the appropriate lines the source used to determine the data entered in columns 1, 2, and 4, as applicable. If necessary, attach appropriate explanations. This column is used to provide information for future reference regarding the data sources and to assist intermediaries in verifying the data and method used to determine the data.

3605.3 Part III - Hospital Wage Index Summary--This worksheet provides for the calculation of a hospital's average hourly wage (without overhead allocation, occupational mix adjustment, and inflation adjustment) as well as analysis of the wage data.

Columns 1 through 5--Follow the same instructions discussed in Part II, except for column 5, line 5.

Line 1--From Part II, enter the result of line 1 minus the sum of lines 2, 3, 4.01, 5, 5.01, 6, 6.01 (10/00), and 7 (10/97). Add to this amount line: 22.01, 26.01 and 27.01. (10/01/2003b)

Line 2--From Part II, enter the sum of lines 8 and 8.01.

Line 3--Enter the result of line 1 minus line 2.

Line 4--From Part II, enter the sum of lines 9, 9.03, 10, 11, and 12 and subscripts if applicable (10/97).

Line 5--From Part II, enter the sum of lines 13, 14, and 18. Enter on this line in column 5 the wage-related cost percentage computed by dividing Part III, column 3, line 5, by Part III, column 3, line 3. Round the result to 2 decimal places.

Line 6--Enter the sum of lines 3 through 5.

Lines 7 through 12--Do not complete these lines (10/97).

Line 13--Enter from Part II above, the sum of lines 21 through 35, including lines 22.01, 26.01, and 27.01. If the hospital's ratio for excluded area salaries to net salaries is greater than 5 percent, the hospital must complete all columns for this line. (See instructions in Part II, lines 21 through 35 for calculating the percentage.)

3606. WORKSHEET S-4 - HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain statistical records for proper determination of costs payable under titles V, XVIII, and XIX. The statistics required on this worksheet pertain to a hospital-based home health agency. The data maintained is dependent upon the services provided by the agency, number of program home health aide hours, total agency home health aide hours, program unduplicated census count, and total unduplicated census count. In addition, FTE data are required by employee staff, contracted staff, and total. Complete a separate S-4 for each hospital-based home health agency.

Line 1--Enter the number of hours applicable to home health aide services.

Line 2--Enter the unduplicated count of all individual patients and title XVIII patients receiving home visits or other care provided by employees of the agency or under contracted services during the reporting period. Count each individual only once. However, because a patient may be covered under more than one health insurance program, the total census count (column 5, line 2) may not equal the sum of columns 1 through 4, line 2. For purposes of calculating the unduplicated census, if a beneficiary has received healthcare in more than one CBSA, you must prorate the count of that beneficiary so as not to exceed a total of (1). A provider is to also query the beneficiary to determine if he or she has received healthcare from another provider during the year, e.g., Maine versus Florida for beneficiaries with seasonal residence. For cost reports that overlap October 1, 2000, subscript line 2 and enter the census count before October 1, 2000 on line 2 and on and after October 1, 2000 on line 2.01. For cost reporting periods that begin on or after October 1, 2000, no subscripting is required for line 2.

Lines 3 through 18--Lines 3 through 18 provide statistical data related to the human resources of the HHA. The human resources statistics are required for each of the job categories specified in lines 3 through 18.

Enter the number of hours in your normal work week.

Report in column 1 the full time equivalent (FTE) employees on the HHA's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the HHA.

Compute staff FTEs for column 1 as follows. Add all hours for which employees were paid and divide by 2080 hours. Round to two decimal places, e.g., .04447 is rounded to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked and divide by 2080 hours.

If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Line 19--For HHA services rendered on or after January 1, 2006, geographic areas are identified as CBSAs. Enter in column 1 the number of CBSAs and in column 1.01 the number of CBSAs you serviced during this cost reporting period (1/1/2006s).

Line 20--Identify each CBSA and/or Non-CBSA (rural) where the reported HHA visits are performed. Subscript the lines to accommodate the number of CBSA's you service. Rural CBSA codes are assembled by placing the digits "999" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 99921 and rural CBSA codes are assembled by placing the digits "99" in front of the two digit State code, e.g., for the state of Maryland the rural CBSA code is 9921.

PPS Activity Data--Applicable for Medicare services rendered on or after October 1, 2000.

In accordance with 42 CFR §413.20 and §1895 of the Social Security Act, home health agencies are mandated to transition from a cost based reimbursement system to a prospective payment system (PPS) effective for home health services rendered on or after October 1, 2000.

The statistics required on this worksheet pertain to home health services furnished on or after October 1, 2000. The data to be maintained, depending on the services provided by the agency, includes the number of aggregate program visits furnished in each episode of care payment category for each covered discipline, the corresponding aggregate program charges imposed in each episode of care payment category for each covered discipline, total visits and total charges for each episode of care payment category, total number of episodes and total number of outlier episodes for each episode of care payment category, and total medical supply charges for each episode of care payment category.

HHA Visits--See PRM II, chapter 32, §3205, page 32-13 for the definition of an HHA visit.

Episode of Care--Under home health PPS the 60 day episode is the basic unit of payment where the episode payment is specific to one individual beneficiary. Beneficiaries are covered for an unlimited number of non-overlapping episodes. The duration of a full length episode will be 60 days. An episode begins with the start of care date and must end by the 60th day from the start of care.

Less than a full Episode of Care--When 4 or fewer visits are provided by the HHA in a 60 day episode period, the result is a low utilization payment adjustment (LUPA). In this instance the HHA will be reimbursed based on a standardized per visit payment.

An episode may end before the 60th day in the case of a beneficiary elected transfer, or a discharge and readmission to the same HHA (including for an intervening inpatient stay). This type of situation results in a partial episode payment (PEP) adjustment.

When a beneficiary experiences a significant change in condition (SCIC) and subsequently, but within the same 60 day episode, elects to transfer to another provider a SCIC within a PEP occurs. *Effective for episodes of care ending on or after January 1, 2008, do not complete column 5 for SCIC within PEP episodes.*

A significant change in condition (SCIC) adjustment occurs when a beneficiary experiences a significant change in condition, either improving or deteriorating, during the 60 day episode that was not envisioned in the original plan of care. The SCIC adjustment reflects the proportional payment adjustment for the time both prior and after the beneficiary experienced the significant change in condition during the 60 day episode. *Effective for episodes of care ending on or after January 1, 2008, do not complete column 6 for SCIC only episodes.*

Use lines 21 through 32 to identify the number of visits and the corresponding visit charges for each discipline for each episode payment category. Lines 33 and 35 identify the total number of visits and the total corresponding charges, respectively, for each episode payment category. Line 36 identifies the total number of episodes completed for each episode payment category. Line 37 identifies the total number of outlier episodes completed for each episode payment category.

Outlier episodes do not apply to 1) Full Episodes without Outliers and 2) LUPA Episodes. Line 38 identifies the total medical supply charges incurred for each episode payment category. Column 7 displays the sum total of data for columns 1 through 6. The statistics and data required on this worksheet are obtained from the provider statistical and reimbursement (PS&R) report and only pertain to services rendered on or after October 1, 2000.

When an episode of care is initiated in one fiscal year and concludes in the subsequent fiscal year, all statistical data (i.e., cost, charges, counts, etc...) associated with that episode of care will appear on the PS&R of the fiscal year in which the episode of care is concluded. Similarly, all data required in the cost report for a given fiscal year must only be associated with services rendered during episodes of care that conclude during the fiscal year. Title XVIII visits reported on this worksheet will not agree with the title XVIII visits reported on Worksheet H-6, sum of columns 6 and 7 line 14.

Columns 1 through 6--Enter data pertaining to title XVIII patients only for services furnished on or after October 1, 2000. Enter, as applicable, in the appropriate columns 1 through 6, lines 21 through 32, the number of aggregate program visits furnished in each episode of care payment category for each covered discipline and the corresponding aggregate program visit charges imposed for each covered discipline for each episode of care payment category. The visit counts and corresponding charge data are mutually exclusive for all episode of care payment categories. For example, visit counts and the corresponding charges that appear in column 4 (PEP only Episodes) will not include any visit counts and corresponding charges that appear in column 3 (LUPA Episode) and vice versa. This is true for all episode of care payment categories in columns 1 through 6.

Line 33--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visits from lines 21, 23, 25, 27, 29 and 31.

Line 34--Enter in columns 1 through 6 for each episode of care payment category, respectively, the charges for services paid under PPS and not identified on any previous lines.

Line 35--Enter in columns 1 through 6 for each episode of care payment category, respectively, the sum total of visit charges from lines 22, 24, 26, 28, 30, 32 and 34.

Line 36--Enter in columns 1 through 6 for each episode of care payment category, respectively, the total number of episodes (standard/non-outlier) of care rendered and concluded in the provider's fiscal year.

Line 37--Enter in columns 2 and 4 through 6 for each episode of care payment category identified, respectively, the total number of outlier episodes of care rendered and concluded in the provider's fiscal year. Outlier episodes do not apply to columns 1 and 3 (Full Episodes without Outliers and LUPA Episodes, respectively).

3608. STATISTICAL DATA OUTPATIENT PROVIDERS

3608.1 Worksheet S-6 - Hospital-Based Outpatient Rehabilitation Provider Data--In accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), maintain statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to hospital-based outpatient rehabilitation providers. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility. For cost reporting periods beginning on or after April 1, 2001, if all services provided by the CORF and for cost reporting periods beginning on or after July 1, 2003, OPTs, OSPs, or OOTs, are paid 100 percent from fee scheduled payments, skip lines 1 through 18 and enter an affirmative response on line 19 of this worksheet and do not complete the corresponding J series worksheets.

This worksheet provides statistical data related to the human resources of the outpatient rehabilitation provider. The data maintained depends on the services provided by the outpatient rehabilitation provider. FTE data is required by employee staff, contracted staff, and total. The human resources statistics are required for each of the job categories specified on lines 1 through 17. Enter any additional categories needed on line 18.

Line 19- Is this component paid 100 percent under established fee schedules? Enter a "Y" and a "N" for no.

Enter the number of hours in your normal work week in the space provided.

Report in column 1 the full time equivalent (FTE) employees on the outpatient rehabilitation provider's payroll. These are staff for which an IRS Form W-2 was issued.

Report in column 2 the FTE contracted and consultant staff of the outpatient rehabilitation provider.

Compute staff FTEs for column 1 as follows. Add hours for which employees were paid divided by 2080 hours, and round to two decimal places, e.g., round .04447 to .04. Compute contract FTEs for column 2 as follows. Add all hours for which contracted and consultant staff worked divided by 2080 hours, and round to two decimal places.

If employees are paid for unused vacation, unused sick leave, etc., exclude the paid hours from the numerator in the calculations.

3608.2 Worksheet S-8 - Provider-Based Rural Health Clinic/Federally Qualified Health Center Provider Statistical Data (1/98)--Effective with services rendered on and after January 1, 1998, in accordance with 42 CFR 413.20(a), 42 CFR 413.24(a), and 42 CFR 413.24(c), you are required to maintain separate statistical records for proper determination of costs payable under the Medicare program. The statistics reported on this worksheet pertain to provider-based rural health clinics (RHCs) and provider-based Federally qualified health centers (FQHCs). If you have more than one of these clinics, complete a separate worksheet for each facility. RHCs and FQHCs may elect to file a consolidated cost report pursuant to CMS Pub. 100-4, chapter 9, §30.8.

Lines 1 and 1.01--Enter the full address of the RHC/FQHC.

Line 2--For FQHCs only, enter your appropriate designation (urban or rural). See §505.2 of the RHC/FQHC Manual for information regarding urban and rural designations. If you are uncertain of your designation, contact your intermediary. RHCs do not complete this line.

Lines 3 through 8--In column 1, enter the applicable grant award number(s). In column 2, enter the date(s) awarded.

Line 9--Subscript line 9 as needed to list all physicians furnishing services at the RHC/FQHC. Enter the physician's name in column 1, and the physician's Medicare billing number in column 2. *This line is not applicable for cost reporting periods ending on or after May 31, 2009.*

Line 10--Subscript line 10 as needed to list all supervisory physicians. Enter the physician's name in column 1, and the number of hours the physician spent in supervision in column 2. *This line is not applicable for cost reporting periods ending on or after May 31, 2009.*

Line 11--If the facility provides other than RHC or FQHC services (e.g., laboratory or physician services), answer "Yes" and enter the type of operation on subscripts of line 12 otherwise enter "N" for no.

Line 12 --Enter in columns 1 through 14 the starting and ending hours in the applicable columns for the days that the facility is available to provide RHC/FQHC services. Enter the starting and ending hours in the applicable columns 1 through 14 for the days that the facility is available to provide other than RHC/FQHC services. When entering time do so as military time, e.g., 2:00 p.m. is 1400.

Line 13--Have you received an approval for an exception to the productivity standards? Enter a "Y" for yes and an "N" for no.

Line 14--Is this a consolidated cost report as defined in the Rural Health Clinic Manual? If yes, enter in column 2 the number of providers included in this report, complete line 15, and complete only one worksheet series M for the consolidated group. If no, complete a separate worksheet S-8 for each component accompanied by a corresponding worksheet M series.

Line 15--Identify provider's name and number filing the consolidated cost report.

Line 16--Are you claiming allowable GME costs for services rendered on and after January 1, 1999, as a result of your substantial payment for interns and residents. If yes, enter the number of program visits in the appropriate column performed by interns and residents (1/99).

Line 17--For cost reporting periods which overlap July 1, 2001, is this is a small urban hospital with under 50 beds based on the calculation method in §3664. Enter a "Y" for yes an "N" for no. If yes, it will be necessary to subscript the columns on M-3 to accommodate the application or exemption of the payment limits.

If an asset for which the Medicare program had recognized depreciation during the base period is disposed of subsequent to the base period, the hospital-specific rate is not revised to recognize the portion of the gain or loss allocated to the base period.

Lines 3 and 4--New capital costs are defined as all allowable Medicare inpatient capital-related costs that do not meet the definition of old capital costs. Betterment or improvement costs related to old capital costs are new capital assets. (See 42 CFR 412.302(a).) Capital costs incurred as a result of extraordinary circumstances are new capital. (See 42 CFR 412.348(e).) Direct assignment of new capital costs must be done in accordance with CMS Pub. 15-I, §2313.

Line 6--Enter administrative and general (A & G) costs on this line. If this line is componentized into more than one cost center, eliminate line 6. Componentized A & G lines must begin with subscripted line 6.01 and continue in sequential order (e.g., 6.01 Nonpatient Telephones; 6.02 Data Processing; 6.03 Purchasing, Receiving, Stores; 6.04 Admitting; 6.05 Cashiering, Accounts; and 6.06 Other A & G).

Line 14--This cost center normally includes only the cost of nursing administration. The salary cost of direct nursing services, including the salary cost of nurses who render direct service in more than one patient care area, is directly assigned to the various patient care cost centers in which the services were rendered. Direct nursing services include gross salaries and wages of head nurses, registered nurses, licensed practical and vocational nurses, aides, orderlies, and ward clerks.

However, if your accounting system fails to specifically identify all direct nursing services to the applicable patient care cost centers, then the salary cost of all direct nursing service is included in this cost center.

Line 17--This cost center includes the direct costs of the medical records cost center including the medical records library. The general library and the medical library are not included in this cost center but are reported in the A & G cost center.

Line 20--Effective for services rendered on or after January 1, 1989, the services of a nonphysician anesthetist generally are paid for by the Part B carrier based on a fee schedule rather than on reasonable cost basis through the cost report. As such, the salary and fringe benefit costs included on line 20 generally are not reimbursed through the cost report.

NOTE: Only such salary and fringe benefit costs are included on this line.

However, payment for the nonphysician anesthetists on a fee basis may not apply to a rural hospital during 1991 if the hospital employed or contracted with not more than one FTE nonphysician anesthetist and, if (1) in 1987, the hospital had 250 or fewer surgical procedures (including inpatient and outpatient procedures) requiring anesthesia services and (2) each nonphysician employed by or under contract with the hospital has agreed not to bill under Part B of title XVIII for professional services furnished. Further, payment under the fee schedule applies to hospitals during 1991 unless the hospital establishes, before the beginning of each of these years, that it did not exceed 800 surgical procedures requiring anesthesia in the previous year. 42 CFR 412.113(c)(2)(ii) (10/1/2002)

Hospitals which do not qualify for the exception and are therefore subject to the fee schedule payment method must remove the salary and fringe benefit costs from line 20. The total amount is reported on Worksheet A-8, line 33 and in column 6, line 20 of this worksheet. This removes these costs from the cost reported in column 7.

Lines 21 and 24--For cost reporting periods beginning on or after October 1, 1990, if you operate an approved nursing or allied health education program that meets the criteria of 42 CFR 413.85 and 412.113(b), both classroom and clinical portions of the costs are allowable as pass through costs as defined in 42 CFR 413.85.

Classroom costs are those costs associated with formal, didactic instruction on a specific topic or subject in a classroom that meets at regular, scheduled intervals over a specific time period (e.g., semester or quarter) and for which a student receives a grade.

Clinical training is defined as involving the acquisition and use of the skills of a nursing or allied health profession or trade in the actual environment in which these skills will be used by the student upon graduation. While it may involve occasional or periodic meetings to discuss or analyze cases, critique performance, or discuss specific skills or techniques, it involves no classroom instruction.

For cost reporting periods beginning on or after October 1, 1990, if you do not operate the program, the classroom portion of the costs are not allowable as pass through costs and therefore not reported on lines 21 and 24 of the Form CMS-2552-96. They may, however, be allowable as routine service operating cost. (See CMS Pub. 15-1, §404.2.) The clinical portions of these costs are allowable as pass through costs if the following conditions as set forth in §4004(b) of OBRA 1990 are met:

1. The hospital must have claimed and have been paid for clinical costs (described below) during its latest cost reporting period that ended on or before October 1, 1989.

2. The proportion of the hospital's total allowable costs that is attributable to the clinical training costs of the approved program and allowable under §4004(b)(1) of OBRA 1990 during a cost reporting period does not exceed the proportion of total allowable costs that were attributable to the clinical training costs during the hospital's most recent cost reporting period ending on or before October 1, 1989.

3. The hospital receives a benefit for the support it furnishes to the education program through the provision of clinical services by nursing and allied health students participating in the program.

4. The clinical training costs must be incurred by the provider or by an educational institution related to the provider by common ownership or control as defined by 42 CFR 413.17b (cost to related organizations). Costs incurred by a third party, regardless of its relationship to either the provider or the educational institution, are not allowed.

5. The costs incurred by the hospital for the program do not exceed the costs that would have been incurred by the hospital if the program had been operated by the hospital.

Line 21--Enter the cost for the nursing school.

Line 22--Enter the cost of intern and resident salaries and salary-related fringe benefits. Do not include salary and salary-related fringe benefits applicable to teaching physicians which are included in line 23.

Line 23--Enter the other costs applicable to interns and residents in an approved teaching program.

Line 24--This line is used for a hospital or subprovider which operates an approved paramedical education program that meets the criteria of 42 CFR 413.85 and 412.113(b). Establish a separate cost center for each paramedical education program (e.g., one for medical records or hospital administration). If additional lines are needed, subscript line 24. If the direct costs are included in the costs of an ancillary cost center, reclassify them on Worksheet A-6 to line 24. Appropriate statistics are required on Worksheet B-1 to ensure that overhead expenses are properly allocated to this cost center.

Lines 25 through 36--These lines are for the inpatient routine service cost centers.

Line 25--The purpose of this cost center is to accumulate the incurred routine service cost applicable to adults and pediatrics (general routine care) in a hospital. Do not include incurred costs applicable to subproviders or any other cost centers which are treated separately.

NOTE: If a rural hospital with a certified SNF which has less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds) has made an election to use swing bed optional method for the SNF, the SNF routine costs and patient days are treated as though they were hospital swing bed-SNF type costs and patient days and are combined with the hospital adults and pediatrics cost center on line 25. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.5B.) The SNF direct costs are reclassified from line 34 to line 25 through Worksheet A-6. On Worksheet B-1, the statistics for line 25 include the statistics for line 34.

When the swing bed optional method is elected for the SNF, the SNF beds are not swing beds but are reimbursed as if they were swing beds.

SNF ancillary services are recorded on Worksheet D, Part III, and Worksheet D-4 as swing bed-SNF ancillary services and not as SNF ancillaries when the swing bed optional method is elected.

Lines 26 through 30--Use lines 26 through 29 to record the cost applicable to intensive care type inpatient hospital units. (See 42 CFR 413.53(b).) Label line 30 appropriately to indicate the purpose for which it is being used.

Line 31--Use this line to record the inpatient routine service costs of a subprovider. Hospital units that are excluded units from PPS are treated as subproviders for cost reporting purposes. If you have more than one subprovider, subscript line 31.

Line 34--Use this line to record the costs of SNFs certified for titles V, XVIII, or XIX if your State accepts one level of care.

Line 35--Use this line to record the cost of NFs certified for title V or title XIX but not certified as an SNF for title XVIII. Subscript this line to record the cost of ICF/MR. Do not report nursing facility costs on this subscripted line (9/96).

Line 36--Use this cost center to accumulate the direct costs incurred in maintaining long term care services not specifically required to be included in other cost centers. A long term care unit refers to a unit where the average length of stay for all patients is greater than 25 days. The beds in this unit are not certified for titles V, XVIII, or XIX.

Lines 37 through 59--Use for ancillary service cost centers.

Line 45--Use this line to record costs when a pathologist continues to bill non-program patients for clinical laboratory tests and is compensated by you for services related to such tests for program beneficiaries. When you pay the pathologist an amount for administrative and supervisory duties for the clinical laboratory for program beneficiaries only, include the cost in this cost center.

NOTE: No overhead expenses are allocated to this cost center since it relates to services for program beneficiaries only. The cost reporting treatment is similar to that of services furnished under arrangement to program beneficiaries only. (See CMS Pub. 15-I, §2314.)

These costs are apportioned among the various programs on the basis of program charges for provider clinical laboratory tests for all programs for which you reimburse the pathologist.

Line 46--Include the direct expenses incurred in obtaining blood directly from donors as well as whole blood and packed red blood cells from suppliers. Do not include in this cost center the processing fee charged by suppliers. The processing charge is included in the blood storing, processing, and transfusion cost center. Identify this line with the appropriate cost center code (Table 5 - electronic reporting specifications) for the cost of administering blood clotting factors to hemophiliacs. Enter on subscripted line 46.30 the applicable costs for blood clotting factors to hemophiliacs. (See §4452 of BBA 1997, OBRA 1989 & 1993.)

Line 47--Include the direct expenses incurred for processing, storing, and transfusing whole blood, packed red blood cells, and blood derivatives. Also include the processing fee charged by suppliers.

Line 55--Include the expense of medical supplies charged to patients. These items are low cost medical supplies generally not traceable to individual patients. Do not include high cost implantable devices on this line. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of charges requisitioned.

Line 55.30--Include the expense of implantable devices charged to patients. The types of items includable on this line are high cost implantable devices chargeable and traceable to individual patients. Do not include low cost medical supplies on this line. When determining what costs are reported in this cost center, providers should use costs associated with implantable devices bearing revenue codes identified in the FR, Vol. 73, No. 161, page 48462, dated August 19, 2008. This amount is generally not input on Worksheet A, but rather allocated to this cost center on Worksheet B from cost center 15 (central service and supply) based on the recommended statistic of charges requisitioned. Identify this line with the appropriate cost center code according to Table 5 of the electronic reporting specifications. This cost center is effective for cost reporting periods beginning on or after May 1, 2009.

Line 57--If you furnish renal dialysis treatments, account for such costs by establishing a separate ancillary service cost center. In accumulating costs applicable to this cost center, include no other ancillary services even though they are routinely administered during the course of the dialysis treatment. However, if you physically perform a few minor routine laboratory services associated with dialysis in the renal dialysis department, such costs remain in the renal dialysis cost center. Outpatient maintenance dialysis services rendered after July 31, 1983, are reimbursed under the composite rate reimbursement system. For purposes of determining overhead attributable to the drugs Epoetin and Aranesp include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

NOTE: ESRD physician supervisory services rendered on or after August 1, 1983, (the effective date of the composite rate reimbursement system) are not included as your costs. Supervisory services are included in the physician's monthly capitation rate.

Line 58--Enter the cost of ASCs that are not separately certified as a distinct part but which have a separate surgical suite. Do not include the costs of the ancillary services provided to ASC patients. Include only the surgical suite costs (i.e., those used in lieu of operating or recovery rooms).

Lines 60 through 63--Use these lines for outpatient service cost centers.

Line 60--Enter the cost applicable to the clinic. If you have two or more clinics which are separately costed, separately report each such clinic. Subscript this line to report each clinic. Carry forward these subscripted lines to all applicable worksheets. If you do not separately cost each clinic, you may combine the cost of all clinics on the clinic line.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, and FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 61--Enter the costs of the emergency room cost center.

Line 62--Do not use this line on this worksheet. If you have an area specifically designated for observation (e.g., observation patients are not placed in a general acute care area bed), report this on a subscripted line 62.01.

NOTE: It is possible to have both a distinct observation bed area and a non-distinct part. For example, your distinct part observation bed area is only staffed from 7:00 a.m. - 10:00 p.m. Patients entering your hospital needing observation bed care after 10:00 p.m. and before 7:00 a.m. are placed in a general inpatient routine care bed. If patients entering the distinct part observation bed area are charged differently than the patients placed in the general inpatient routine care bed, separate the costs into distinct observation bed costs and non-distinct observation bed costs. However, if the charge is the same for both patients, report all costs and charges as distinct part observation beds.

Line 63--Use this line to report the costs of provider-based RHCs and FQHCs. If more than one are maintained and/or other services are reported on this line, subscript the line. See Table 5 in §3695 for the proper cost center code for RHCs and FQHCs. When reporting RHCs and FQHCs on these lines, subscript the line beginning with lines 63.50 through 63.59 and 63.85 through 63.99 for RHC and 63.60 through 63.84 for FQHC.

In accordance with CMS Pub. 27, §501, compensation paid to a physician for RHC services rendered in a hospital-based RHC is cost reimbursed. Where the physician agreement compensates for RHC services as well as non-RHC services, or services furnished in the hospital, the related compensation must be eliminated on Worksheet A-8 and billed to the Part B carrier. If not specified in the agreement, a time study must be used to allocate the physician compensation.

Lines 64 through 68 and 70--Use these lines for other reimbursable cost centers (other than HHA, CORF, and CMHC).

Line 64--Use this line to accumulate the direct costs incurred for self-care home dialysis. For purposes of determining overhead attributable to the drugs Epoetin *and Aranesp* include the cost of the drug in this cost center. The drug costs will be removed on worksheet B-2 after stepdown.

A Medicare beneficiary dialyzing at home has the option to deal directly with the Medicare program and make individual arrangements for securing the necessary supplies and equipment to dialyze at home. Under this arrangement, the beneficiary is responsible for dealing with the various suppliers and the Medicare program to arrange for payment. The beneficiary is also responsible to the suppliers for the deductible and 20 percent Medicare coinsurance requirement. You do not receive composite rate payment for a patient who chooses this option. However, if you provide any direct home support services to a beneficiary who selects this option, you are reimbursed on the same reasonable cost basis for these services as for other outpatient services. These costs are entered on line 63 and are notated as cost reimbursed. You may service Medicare beneficiaries who elect this option and others who deal directly with you. In this case, set up two home program dialysis cost centers (using a subscript for the second cost center) to properly classify costs between the two categories of beneficiaries (those subject to cost reimbursement and those subject to the composite rate).

Line 65--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line (9/96).

Lines 66 and 67--Use these lines to report durable medical equipment rented or sold, respectively.

For the hospital-based SNF, report support surfaces by subscribing line 67 and use the proper cost center code.

Line 69--This cost center accumulates the direct costs for outpatient rehabilitation providers, CORF, CMHC, OPT, OOT, and OSP. If you have multiple components, subscript this line using the proper cost center code.

Line 70--Use this line if your hospital operates an intern and resident program not approved by Medicare.

Line 71--This cost center accumulates costs specific to HHA services. If you have more than one certified hospital-based HHA, subscript line 71 for each HHA.

Provider-based HHAs are operated and managed in a variety of ways within the context of the health care complexes of which they are components. In some instances, there are discrete management and administrative functions pertaining to the HHA, the cost of which is readily identifiable from the books and records.

In other instances, the administration and management of the provider-based HHA is integrated with the administration and management of the health care complex to such an extent that the cost of administration and management of the home health agency can be neither identified nor derived from the books and records of the health care complex. In other instances, the cost of administration and management of the HHA is integrated with the administration and management of the health care complex, but the cost of the HHA administration and management can be derived through cost finding. However, in most cases, even when the cost of HHA administration and management can be either identified or derived, the extent to which the costs are applicable to the services furnished by the provider-based HHA is not readily identifiable.

Even when the costs of administration and management of a provider-based HHA can be identified or derived, such costs do not generally include all of the general service costs (i.e., overhead costs) applicable to the HHA. Therefore, allocation of general service costs through cost finding is necessary for the determination of the full costs of the provider-based HHA.

When the provider-based HHA can identify discrete management and administrative costs from its books and records, these costs are included on line 71.

Similar situations occur for the services furnished by the provider-based HHA. For example, in some instances, physical therapy services are furnished by a discrete HHA physical therapy department. In other instances, physical therapy services are furnished to the patient of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the direct costs of furnishing the physical therapy services to the patients of the provider-based HHA cannot be readily identified or derived. In other instances, physical therapy services are furnished to patients of the provider-based HHA by an integrated physical therapy department of a hospital health care complex in such a manner that the costs of physical therapy services furnished to patients of the provider-based HHA can be readily identified or derived.

When you maintain a separate therapy department for the HHA apart from the hospital therapy department furnishing services to other patients of the hospital health care complex or when you are able to reclassify costs from an integrated therapy department to an HHA therapy cost center, make a reclassification entry on Worksheet A-6 to the appropriate HHA therapy cost center. Make a center. Make a similar reclassification to the appropriate line for other ancillaries when the HHA costs are readily identifiable.

NOTE: This cost report provides separate HHA cost centers for all therapy services. If services are provided to HHA patients from a shared hospital ancillary cost center, make the cost allocation on Worksheet H-4, Part II.

Lines 72 through 81--Do not use these lines.

Lines 82 through 93--Use these lines for special purpose cost centers. Special purpose cost centers include kidney, heart, liver, and lung acquisition costs, costs of other organ acquisitions which are nonreimbursable but which CMS requires for data purposes, cost centers which must be reclassified but which require initial identification, and ASC and hospice costs which are needed for rate setting purposes.

NOTE: Prorate shared acquisition costs (e.g., coordinator salaries, donor awareness programs) among the type of organ acquisitions. Generally, this is done based on the number of organs procured. Further, if multiple organs have been procured from a community hospital or an independent organ procurement organization, prorate the cost among the type of acquisitions involved.

Line 82--Record any costs in connection with lung acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 83--This cost center includes the cost of services purchased under arrangement or billed directly to the hospital in connection with kidney acquisition. Such direct costs include but are not limited to:

- o Fees for physician services (preadmission for transplant donor and recipient tissue-typing and all tissue-typing services performed on cadaveric donors);
- o Cost for kidneys acquired from other providers or kidney procurement organizations;
- o Transportation costs of kidneys;
- o Kidney recipient registration fees;
- o Surgeons' fees for excising cadaveric donor kidneys; and
- o Tissue-typing services furnished by independent laboratories.

NOTE: No amounts or fees paid to a donor, their estate, heirs, or assigns in exchange for a kidney or for the right to remove or transplant a kidney are included in kidney acquisition costs. Also, such amounts or fees are not included in any other revenue producing or general service cost center.

Only hospitals which are certified transplant centers are reimbursed directly by the Medicare program for organ acquisition costs. All such costs are accumulated on Worksheet D-6.

Hospitals which are not certified transplant centers are not reimbursed by the Medicare program for organ acquisition costs. Such hospitals sell any organs excised to a certified transplant center or an organ procurement organization. The costs are accumulated in this cost center and flow through cost finding to properly allocate overhead costs to this cost center. However, only a certified transplant center completes Worksheet D-6.

Line 84--Record any costs in connection with liver acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85--Record any costs in connection with heart acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85.01--Record any costs in connection with pancreas acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 85.02 -- Record any costs in connection with intestinal acquisitions. This cost center flows through cost finding and accumulates any appropriate overhead costs.

Line 85.03--Record the costs associated with the acquisition of the pancreas that is used to isolate the islet cells that are used for transplant. Do not include in this cost any costs associated with the isolation of the islet cells as these costs will be included as an add-on to the DRG payment. (See CR 5505 dated March 2, 2007 with an effective date for discharges on or after 10/1/04). Use non-standard cost center code 8530 to identify this cost center.

Line 86--Record any costs related to organ acquisitions, which are not already recorded on lines 82, 83, 84, 85 and subscripts. This cost center flows through cost finding and accumulates any appropriate overhead costs (8/99).

Line 87--Do not use this line.

Line 88--Enter all interest paid by the facility. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

NOTE: If capital-related and working capital interest are commingled on this line, reclassify working capital interest to A & G expense. Reclassify capital-related interest to lines 1 through 4, as appropriate, in accordance with the instructions for those lines.

Line 89--Include only utilization review costs of the hospital-based SNF. All costs are either reclassified or adjusted in total depending on the scope of the review. If the scope of the review covers all patients, all allowable costs are reclassified in column 4 to A & G expenses (line 6). If the scope of the review covers only Medicare patients or Medicare, title V, and title XIX patients, then (1) in column 4, reclassify to A & G expenses all allowable costs other than physicians' compensation and (2) deduct in column 6 the compensation paid to the physicians for their personal services on the utilization review committee. The adjusted amount is then reinstated on Worksheet D-1, line 81 for each program. The sum of the amounts reported on each Worksheet D-1 and/or the amount reported on Worksheet E-2, column 1, line 7 must equal the amount adjusted on Worksheet A-8 (9/96).

Line 90--In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost. After reclassifications in column 4 and adjustments in column 6, the balance in column 7 must equal zero. This line cannot be subscripted.

A PPS hospital or a complex with a PPS excluded unit which is paid for PPS inpatient capital using the hold harmless method is required to allocate the costs in this cost center between old and new capital and between buildings and fixtures and movable equipment on the basis of the ratio of the hospital's gross old asset value to total asset value in each cost reporting period on Worksheet A-7, Part III.

Columns 5, 5.01 and 5.02--For title XVIII, enter the charges for outpatient services not included in any other column in Part V. For SNFs for services rendered which overlap the effective date of January 1, 1998, for physical, occupational and speech therapy (lines 50 through 52) subscript this column and report charges before January 1, 1998, in column 5 and on and after January 1, 1998, in column 5.01. Subscripting is not required for cost reporting periods beginning on or after January 1, 1998. For hospitals claiming ambulance services for cost reporting periods which overlap October 1, 1997, subscript column 5. Enter on line 65, column 5 the charges relating to the period on or after October 1, 1997, and in column 5.01 the charges relating to prior to October 1, 1997. For cost reporting periods beginning on or after October 1, 1997, do not complete column 5.01 for ambulance. Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges. Do not include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis. These charges are reported on Worksheet D, Part VI. Do not include in Medicare charges any charges identified as MSP/LCC. Effective August 1, 2000, enter in column 5 the services prior to August 1, 2000, paid based on cost. In column 5.01 enter the charges for services rendered on or after August 1, 2000, paid subject to the prospective payment system. These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy. Create separate subscripted column (e.g. 5.03, 5.04) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and when a provider experiences a geographic reclassification from urban to rural. However, no subscripting is required when a provider geographically reclassifies from rural to urban. In column 5.02 enter the charges for services rendered on and after August 1, 2000, e.g., for drugs and supplies related to ESRD dialysis (excluding EPO, and any drugs or supplies paid under the composite rate), and corneal tissue. For cost reporting periods which overlap August 1, 2000, report ambulance service charges prior to August 1st, in column 5 and services on and after August 1st in column 5.02. Do not include in any column services excluded from OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab. Hospitals with cost reporting periods which overlap August 1, 2000, report in columns 1.02 through 5 the applicable amounts for services render prior to August 1, 2000, report in column 5.01 the applicable PPS amounts for services on or after August 1, 2000, and report in column 5.02 the cost of services on or after August 1, 2000 which were erroneously paid at cost.

For cost reporting periods beginning on or after January 1, 1999, for SNF, CAHs, and title XIX services not paid under PPS no subscripting is required. Report all charges in column 5.

For CAHs (BIPA §205), enter the charges for the period you are subject to the limit and/or blend and the subscripted line the charges for which you are exempt from the limit and/or blend (see Worksheet S-2, line 30.03). If you are exempt for the full cost reporting period only complete line 65, no subscripts are required.

For cost reporting periods overlapping 4/1/2002 and after subscript line 65 for ambulance services in accordance with the subscripts on Worksheet S-2, line 56 and report charges separately on line 65 and subscripts for the applicable periods. Do not subscript line 65 for cost reporting periods beginning on or after 1/1/2006, as the ambulance PPS payment blend will transition to 100 percent fee based payments and do not report charges for ambulance services rendered on or after January 1, 2006.

Columns 6 and 6.01--Multiply the charges in column 2 and 2.01 by the ratios in column 1, and enter the result. Line 101 equals the sum of lines 37 through 68.

Columns 7 and 7.01--Multiply the charges in column 3 and 3.01 by the ratios in column 1, and enter the result.

Columns 8 and 8.01--Multiply the charges in column 4 and 4.01 by the ratios in column 1, and enter the result.

Columns 9, 9.01, and 9.02--Multiply the charges in column 5 by the ratios in column 1, and enter the result. For hospitals subject to outpatient prospective payment, multiply the charges in column 5.01 and 5.02, or any additional subscripted column of column 5 by the ratios in column 1.01, and enter the result in columns 9.01 and 9.02 or additional subscripts, respectively. For SNFs subscript this column and report the result of multiplying the ratio in column 1 by the charges in columns 5 and 5.01 for physical and occupational therapies, and speech pathology. For lines 50 through 52 only, for services rendered on and after January 1, 1998, enter in column 9.01, 90 percent of the result of multiplying the ratio in column 1 by the charges in column 5.01. For SNF services rendered on and after January 1, 1999, make no entry for therapy services paid under a fee schedule for lines 50 through 52. The amount entered on line 65 of this column, Ambulance, for all providers, cannot exceed the payment limit calculated from Worksheet S-2, column 2, lines 56 and 56.01 (if applicable), times the amount on Worksheet S-3, Part I, column 4, line 27 and 27.01 (if applicable) respectively, for ambulance services on or after October 1, 1997. For cost reporting periods which overlap the October 1, 1997, effective date, enter in column 9 the lower of the cost (column 1 times column 5, rounded to zero, or the limit (Worksheet S-2, Column 2, line 56, times, Worksheet S-3, Part I, column 4, line 27, rounded to zero), added to column 1 times column 5.01 rounded to zero). Hospitals with cost reporting periods that overlap August 1, 2000, subscript column 9 in accordance with column 5 instructions.

For cost reporting periods beginning on or after October 1, 1997, costs for ambulance services are calculated from column 5 charges only. For cost reporting periods which overlap August 1, 2000, to calculate the ambulance costs, multiply the charges reported in column 5 by the appropriate ratio in column 1 and multiply the charges reported in columns 5.01 by the appropriate ratio in column 1.01 and add the results. Compare that to the limit amount calculated as indicated above and enter the lesser of the two in column 9.02.

Ambulance services on or after 4/1/2002 through 12/31/2005 are reimbursed on a blend of the lesser of the cost (the lesser of the cost to charge ratio times charges or limit (applicable limit from Worksheet S-2, line 56 and subscripts, column 2 times the corresponding trips from Worksheet S-3, line 27 and subscripts, column 4)) times 80 percent plus the fee schedule amounts (from Worksheet S-2, line 56 and subscripts, column 4) times 20 percent for the calendar year services beginning 4/1/2002. Subsequent dates and blends (cost percentage/fee percentage) are: Calendar year 2003 is 60/40, 2004 is 40/60, 2005 is 20/80, and 2006 and after is 100 percent fee schedule amounts. Once ambulance payment has transitioned to 100 percent of the fee amount (services rendered on or after 1/1/2006), line 56 will no longer include fee schedule payments.

Generally, CAHs follow the instructions for ambulance services subject to the limit (10/1/97b) and/or the blend (4/1/02s). However, CAHs eligible for cost reimbursement for ambulance (Worksheet S-2, line 30.03, column 1 = "Yes") multiply column 1 times column 5 and enter the result. (12/21/00s)

Column 10--Enter in this column the hospital inpatient Part B charges for services rendered prior to August 1, 2000 (10/1/90s).

Column 11--Enter in this column the hospital inpatient Part B costs computed by multiplying the charges in column 10 times the cost to charge ratio reported in column 1.02 (10/1/90s).

Line Descriptions

Line 44--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services rendered on or after November 29, 1999 will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital

laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2008 (Medicare, Medicaid, and SCHIP Extension Act of 2007, section 107). For title V and XIX purposes, follow applicable State program instructions.

For CAHs effective for services rendered on or after July 1, 2009, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, section 148 and CR 6395, transmittal 1729, dated May 8, 2009.

Line 45--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §3610 for a more complete description on the use of this cost center. For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

NOTE: Since the charges on line 45 are also included on line 44, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 103.

Line 55--Enter in columns 2 through 5 the charges for medical supplies charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 55.30--Enter in columns 2 through 5 the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics. See section 3610 line 55.30

Line 56--Enter the program charges for drugs charged to patients. Include charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under OPSS such as hepatitis vaccines. Do not include vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance. These charges are reported on Worksheet D, Part VI.

Line 57--The only renal dialysis services entered on this line are for inpatients who are not reimbursed under the composite rate regulations. (See 42 CFR 413.170.) Therefore, include only inpatient Part B charges on this line in column 5. Enter the related costs in column 9.

Line 58--Enter in columns 2 and 2.01 the outpatient ASC facility charges for the hospital nondistinct part ambulatory surgery center. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient. Enter in column 5 all other Part B charges applicable to services performed in the nondistinct ASC.

Lines 60 through 63--Use these lines for outpatient service cost centers.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Line 62--Enter in columns 2 through 5 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the nondistinct observation beds and released. These patients were not admitted as inpatients.

Line 64--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program

dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 65--Enter in column 5.02 the total ambulance charges for PPS hospital providers (column 5 for non PPS hospitals). (8/2000)

Line 66 and 67--For title XVIII, DME is paid on a fee schedule through the carrier and, therefore, is not paid through the cost report.

Line 101--Enter the sum of lines 37 through 68.

Line 102--Generally, nonphysician anesthetist services are not subject to the ASC payment methodology for outpatient ambulatory surgical procedures performed in hospitals and as such are not reported on this worksheet unless you meet the exception described in §3610. Do not complete this line if you do not qualify for the exception. If the services meet the criteria for continued cost reimbursement, exclude nonphysician anesthetist charges from ASC charges in columns 2 and 2.01, line 102 and add these charges to column 5, line 102. Do not reduce the charges reported in columns 2 and 2.01, lines 37 through 68 (nor do you increase the charges in column 5) for CRNA charges. The reduction and addition are done in total on line 102. However, if you have separate charges for nonphysician anesthetists reported in the ancillary service cost centers where the services were performed, and the apportionment between ASC and all other Part B is not necessary, enter those charges directly in column 5, line 102, for services rendered before August 1, 2000. These costs are pass through costs when eligible for the exception and are reported on Worksheet D, Part IV.

EXAMPLE: If nonphysician anesthetist charges are included in operating room and anesthesiology charges reported on Worksheet D, Part V, column 2, lines 37 and 40, respectively, eliminate the charges from columns 2 and 2.01 and report them in column 5. This is accomplished by developing a ratio of each affected cost center's nonphysician anesthetist cost allocated on Worksheet B, Part I, column 20, lines 37 and 40 to the total cost reported on Worksheet B, Part I, column 27, lines 37 and 40. Each ratio is then multiplied by the charges applicable to Worksheet D, Part V, columns 2 and 2.01, lines 37 and 40. The result represents the CRNA charges for operating room and anesthesiology. These charges are added together and reported on line 102 as a decrease in columns 2 and 2.01 and an increase to column 5. Attach a separate reconciliation to the cost report showing this computation.

Step Instructions

- 1 $\frac{\text{Worksheet B, Part I, column 20, line 37}}{\text{Worksheet B, Part I, column 27, line 37}} = \text{ratio (six decimal places)}$
- 2 $\frac{\text{Worksheet B, Part I, column 20, line 40}}{\text{Worksheet B, Part I, column 27, line 40}} = \text{ratio (six decimal places)}$
- 3 The ratio in step 1 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 37 equals the CRNA operating room charges.
- 4 The ratio in step 2 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 40 equals the CRNA anesthesiology charges.
- 5 Add the amounts in steps 3 and 4. Enter the total on line 102 as a decrease in columns 2 and 2.01 and as an increase in column 5, line 102.

6 To determine the costs reported in columns 6 and 9, line 102, multiply the ratio on Worksheet C, Part II, column 8, as applicable for each cost center (lines 37 and 40), by the charges computed in steps 3 and 4. Add these two costs together, and report the total as a decrease to columns 6 and 6.01 and an increase to column 9.

Line 103--Enter in column 5 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 45. Do not complete this line for column 9.

Line 104--Enter in columns 5 and 9, and subscripts, the amount on line 101 plus or minus the amounts on lines 102 and 103 if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 to Worksheet E, Part B, line 6. Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than PPS), transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 plus the amount from Worksheet D-4, column 2, line 103 to the appropriate Worksheet E-3, Part III, column 1, line 11.

For titles V and XIX (under PPS), transfer the amount in column 5, line 104 to the appropriate Worksheet E-3, Part III, column 1, line 11.

NOTE: If the amount on line 104 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges, and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Transfer References

<u>From Wkst. D, Part V</u>	<u>Title XVIII, Part B Swing Bed</u>	<u>To</u>	<u>Titles V or XIX or Title XVIII, Part B</u>
Columns 6 & 6.01, line 104	N/A		Wkst. E, Part C, col. 1& 1.01, line 6
Columns 2 & 2.01, line 104	N/A		Wkst. E, Part C, col. 1& 1.01, line 7
Columns 7 & 7.01, line 104	N/A		Wkst. E, Part D, col. 1& 1.01, line 6
Columns 3 & 3.01, line 104	N/A		Wkst. E, Part D, col. 1& 1.01, line 7
Columns 8 & 8.01, line 104	N/A		Wkst. E, Part E, col. 1 & 1.01, line 6
Columns 4 & 4.01, line 104	N/A		Wkst. E, Part E, col. 1 & 1.01, line 7
Columns 9 and subscripts & column 11, Line 104	N/A		Wkst. E, Part B, col. 1 (& subscripts), line 1 & 1.01

Transfer References

<u>From Wkst. D, Part V</u>	<u>Title XVIII, Part B Swing Bed</u>	<u>To</u>	<u>Titles V or XIX or Title XVIII, Part B</u>
Sum of columns 5, 5.01 (SNF only) and 5.02, line 104	N/A		Wkst. E, Part B, line 6 or Wkst. E-3, Part III, col. 1, line 11 for titles V or XIX
Sum of columns 9 and 9.01 (SNF only) through 12/31/98 line 104	Wkst E-2 col. 2, line 3		Wkst. E, Part B, line 1 or Wkst. E-3, Part III, col. 1, line 2 for titles V or XIX

3621.6 Part VI - Vaccine Cost Apportionment--This worksheet provides for the apportionment of costs applicable to the administration and cost of the drug for the following vaccines: Pneumococcal, Influenza, and Osteoporosis. These charges include, if applicable, vaccine services provided by hospital based RHC/FQHC which cannot be reported on Worksheet M-3 and M-4 (1/98). For services rendered on and after August 1, 2000 for vaccines provided by a RHC/FQHC will be reported on Worksheets M-3 and M-4. Pneumococcal and Influenza vaccines rendered on or after January 1, 2003 have transitioned back to cost reimbursed.

For services rendered prior to 4/1/2001 vaccines are reimbursed under cost. For services rendered from 4/1/2001 through 12/31/2002 vaccines are reimbursed under OPPS and will be included in the OPPS PS&R. Therefore vaccine cost will be included in worksheet D, Part V, columns 5.01 or 5.03 amounts for 4/1/2001 through 12/31/2002 (reimbursed at 80% of cost subject to coinsurance and deductibles) and flow to the proper lines on Worksheet E, Part B. For vaccines reimbursed at 100% of cost not subject to coinsurance and deductibles (pneumococcal and influenza vaccines rendered on or after January 1, 2003) Worksheet D, Part VI, line 3, will be transferred to Worksheet E, Part B, line 1.

Line 1--Enter the cost to charge ratio from Worksheet C, Part I, column 9, line 56.

Line 2--Enter the program charges from the PS&R or from provider records. Effective for services rendered on or after April 1, 2001, subscript this line and report charges prior to April 1, 2001, on line 2 and on line 2.01 charges on or after April 1, 2001. For cost reporting periods beginning on or after April 1, 2001, no subscripting is required except for cost reporting periods which overlap January 1, 2003.

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines and the charges for hepatitis B vaccines on worksheet D, Part V as hepatitis B vaccine charges are subject to deductibles and coinsurance.

Line 3--Multiply line 1 times line 2, for hospital services rendered prior to April 1, 2001, and enter the result on line 3. For services rendered on or after April 1, 2001, subscript this line and enter on line 3.01 the result of line 1 times line 2.01. For cost reporting periods beginning on or after April 1, 2001, no subscripting is required, except for cost reporting periods which overlap January 1, 2003. For hospitals for title XVIII, transfer the amount on line 3 to Worksheet E, Part B, line 1 for services rendered prior to April 1, 2001 and on or after January 1, 2003. The amount on line 3.01 is added to

the amount reported on Worksheet D, Part V, column 9.01, line 104 and transferred to Worksheet E, Part B, line 1.01 for services rendered on or after April 1, 2001 and before January 1, 2003. For SNFs transfer to Worksheet E, Part B, line 1, the sum of lines 3 and 3.01, but for reporting periods beginning on or after April 1, 2001, transfer the amount from line 3 only. For swing bed SNFs transfer the amount from line 3 to Worksheet E-2, column 2, line 3 and for NFs to Worksheet E-3, Part III, column 1, line 2, for titles V and XIX.

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines. Transfer the amount on line 3 to Worksheet E, Part B, line 1.

3622. WORKSHEET D-1 - COMPUTATION OF INPATIENT OPERATING COST

This worksheet provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment). All providers must complete this worksheet.

Complete a separate copy of this worksheet for the hospital, each subprovider, hospital-based SNF, and hospital-based other nursing facility. Also, complete a separate copy of this worksheet for each health care program under which inpatient operating costs are computed. When this worksheet is completed for a component, show both the hospital and component numbers.

At the top of each page, indicate by checking the appropriate line the health care program, provider component, and the payment system for which the page is prepared.

Worksheet D-1 consists of the following four parts:

- Part I - All Provider Components
- Part II - Hospital and Subproviders Only
- Part III - Skilled Nursing Facility and Other Nursing Facility Only
- Part IV - Computation of Observation Bed Cost

NOTE: If you have made a swing bed election for your certified SNF, treat the SNF costs and patient days as though they were hospital swing bed-SNF type costs and patient days on Parts I and II of this worksheet. Do not complete Part III for the SNF. (See CMS Pub. 15-I, §2230.9B.)

Definitions

The following definitions apply to days used on this worksheet.

Inpatient Day--The number of days of care charged to a beneficiary for inpatient hospital services is always in documented units of full days. A day begins at midnight and ends 24 hours later. Use the midnight to midnight method in reporting the days of care for beneficiaries even if the hospital uses a different definition for statistical or other purposes.

through 4.04. Complete this portion only if you answered yes to line 21.01 of Worksheet S-2. For cost reporting periods which overlap January 20, 2000, do not complete lines 4 through 4.03 and enter on line 4.04 the manually calculated DSH payment adjusted by the appropriate reduction. (See intermediary PM A-99-62 for proper determination of DSH adjustment.) For those hospitals experiencing a change in the DSH percentage as a result of the application of the BIPA provisions effective for services on and after April 1, 2001, or as a result of the application of the MMA provisions effective for discharges on and after April 1, 2004, (i.e., geographic reclassification) subscript column 1 (add column 1.01) for lines 1, 1.01, 1.02, 1.07, 4.03 and 4.04 and apply the appropriate percentage for the DSH payment and reduction in accordance with the payment dates prescribed above. Review the payment chart on page 137 and lines 1, 1.01, 1.02 and 1.07 for proper reporting of payments. Do not subscript the column for lines 4.03 and 4.04, except as applicable for SCH\MDH and geographic reclassification.

Line 4--Enter the percentage of SSI recipient patient days to Medicare Part A patient days. (Obtain the percentage from your intermediary.)

Line 4.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12 minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

For cost reporting periods beginning on or after October 1, 2004, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, plus column 5.01, line 26, minus the sum of lines 3 and 4) to total days reported on Worksheet S-3, column 6, line 12, plus column 6.01, line 26, minus the sum of lines 3 and 4. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 4.02--Add lines 4 and 4.01 to equal the hospital's DSH patient percentage.

Line 4.03--Compare the percentage on line 4.02 with the criteria described in 42 CFR 412.106(c) and (d). Enter the percentage identified in the CFR to be applied against PPS payments.

For cost reporting periods with dates of service in the period April 1, 2001, through September 30, 2001, or April 1, 2004, through September 30, 2004, enter in column 0 the percentage to be applied against PPS payment for the period April 1 through September 30. In addition, for MDH providers for cost reporting periods overlapping October 1, 2006, the rural 12 percent DSH payment cap does not apply for discharges occurring on or after October 1, 2006. Enter in column 1 the percentage to be applied for discharges occurring prior to October 1, 2006, and enter in column 1.01 the percentage to be applied for discharges occurring on or after October 1, 2006.

NOTE: For cost reporting periods ending on or after October 1, 2004 and before October 1, 2006, 42 CFR 412.102 provides for a transition to a rural DSH payment amount from a urban payment amount over two years, for hospitals that were considered urban under the MSA definition, but are considered rural under the CBSA definition. Impacted hospitals whose DSH payment adjustment exceeds 12 percent will receive 2/3 of the difference between the urban and rural operating DSH for FY 2005 and 1/3 of the difference between the urban and rural operating DSH for FY 2006.

Line 4.04--Multiply line 4.03 by the sum of lines 1, 1.01, 1.02 and 2 and enter the result. For discharges occurring on or after October 1, 1997, multiply line 4.03 by the sum of lines 1, 1.01, and 1.02. For cost reporting periods with dates of service in the period April 1, 2001 through September 30, 2001 or April 1, 2004 through September 30, 2004, add to this amount the product of the payment percentage identified on line 4.03, column 0, applied to the payments

identified on line 1.07. Reduce that amount for discharges occurring on or after October 1, 1997, by 1 percent; 2 percent for October 1, 1998, 3 percent for October 1, 1999; 3 percent for October 1, 2000 through March 31, 2001; 1 percent for April 1, 2001 through September 30, 2001; 3 percent for October 1, 2001 through September 30, 2002; and 0 (zero) percent thereafter. Review the payment chart on page 137 for the proper splitting of payments before and on or after October 1 and April 1 for those cost reports that overlap these dates in order to properly calculate the reduction.

High Percentage of ESRD Beneficiary Discharges Adjustment.--Calculate the additional payment amount allowable for a high percentage of ESRD beneficiary discharges pursuant to 42 CFR 412.104. *When the average weekly cost per dialysis treatment changes within a cost reporting period, create a subscripted column 1.01 for lines 5.01 and 5.05.*

Line 5--Enter total Medicare discharges reported on Worksheet S-3, Part I, excluding discharges for DRGs 302, 316, and 317, or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447).

Line 5.01--Enter total Medicare discharges for ESRD beneficiaries who received dialysis treatment during an inpatient stay (see Vol. 69, FR 154, dated August 11, 2004, page 49087) excluding DRGs 302, 316, and 317, or effective October 1, 2007, excluding MS-DRGs 652, 682, 683, 684, and 685 (see FR 161, Vol. 73, dated August 19, 2008, pages 48520 and 48447).

Line 5.02--Divide line 5.01 by line 5. If the result is less than 10 percent, you do not qualify for the ESRD adjustment.

Line 5.03--Enter the total Medicare ESRD inpatient days excluding DRGs 302, 316, and 317 or effective October 1, 2007, MS-DRGs 652, 682, 683, 684, and 685, as applicable.

Line 5.04--Enter the average length of stay expressed as a ratio to 7 days. Divide line 5.03 by line 5.01 and divide the result by 7 days.

Line 5.05--Enter the average *weekly* cost per dialysis treatment of *\$401.43* (*\$133.81* times the average number of treatments (3)). *See CR 6216, Transmittal 98, dated December 12, 2008. This amount is subject to change on an annual basis. Consult the appropriate CMS change request for future rates.*

Line 5.06--Enter the ESRD payment adjustment (line 5.04, *column 1* times line 5.05, *column 1* times line 5.01, *column 1 plus, if applicable, line 5.04, column 1 times line 5.05, column 2 times line 5.01, column 2*).

Line 6--Enter the sum of lines 1, 1.01, 1.02, 1.07, 2, 2.01, 3.03 (for cost reporting periods which overlap October 1, 1997, and thereafter, substitute line 3.24 for line 3.03), 4.04 (subscripted columns), and 5.06. For cost reporting periods beginning in the government's fiscal year in 1998 and 1999 and you answered yes to line 55 of Worksheet S-2, add to this sum the amount on line 1.06, if applicable.

Line 7-- Sole community hospitals are paid the highest rate of the Federal payment rate, the hospital-specific rate (HSR) determined based on a Federal fiscal year 1982 base period (see 42 CFR 412.73), or the hospital-specific rate determined based on a Federal fiscal year 1987 base period. (See 42 CFR 412.75.) For discharges occurring on or before October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 50 percent of the amount of the excess over the Federal rate of the higher of either the 1982 base period, or the 1987 base period hospital specific rate. For discharges occurring on or after October 1, 2006, Medicare dependent hospitals are paid the highest of the Federal payment rate, or the Federal rate plus 75 percent of the amount of the excess over the Federal rate of the highest rate for the 1982, 1987 or 2002 base period hospital specific rate. For SCHs and Medicare dependent/small rural hospitals, enter the applicable hospital-specific payments.

For sole community hospitals only, the hospital-specific payment amount entered on this line is supplied by your fiscal intermediary. Calculate it by multiplying the sum of the DRG weights for the period (per the PS&R) by the final per discharge hospital-specific rate for the period. For new hospital providers established after 1987, do not complete this line. Use the higher of the hospital-specific rate based on cost reporting periods beginning in FY 1982 or FY 1987. Use the hospital-specific rate (operating cost per discharge divided by the case mix index for 1982 or 1987, as applicable) updated to the beginning of the cost reporting period and adjusted for budget neutrality, if applicable, in this calculation. For services rendered on or after October 1, 2003, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, or 1996.

Additionally, for sole community hospitals only for cost reporting periods beginning on or after January 1, 2009, use the hospital specific rate based on the higher of the cost reporting periods beginning in FY 1982, 1987, 1996, or 2006. (See 42 CFR 412.78.)

For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, an MDH can use a FY 2002 hospital specific rate.

Line 7.01--In addition to the comparison of 1982 and 1987, sole community hospitals can compare the hospital specific rate for cost reporting periods beginning in FY 1996 (CFR 412.77). For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003, enter on this line the hospital-specific payment amount based on the cost reporting period beginning in FY 1996 as supplied by your fiscal intermediary. For services rendered on or after October 1, 2003, do not use this line, but rather use line 7.

Line 8--For SCHs, enter the greater of line 6 or 7. For MDHs (for discharges occurring on or after October 1, 1997, and before October 1, 2006), if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 50 percent of the amount that line 7 exceeds line 6. For MDH discharges occurring on or after October 1, 2006, and before October 1, 2011, if line 6 is greater than line 7, enter the amount on line 6. Where line 7 is greater than line 6, enter the amount on line 6, plus 75 percent of the amount that line 7 exceeds line 6. Hospitals not qualifying as SCH or MDH providers will enter the amount from line 6.

For hospitals subscribing column 1 of line 6 due to a change in geographic location, this computation will be computed separately for each column, and the sum of the calculations will be entered in column 1 of this line.

For SCHs with cost reporting periods beginning on or after October 1, 2000 and before October 1, 2003 - The transition into the FY 1996 rate is actually a blend based on discharges for FY 2001 (October 1, 2000 - September 30, 2001) of 75 percent of the higher of the 1982, 1987, or Federal amount and 25 percent of 1996. For FY 2002 (October 1, 2001 - September 30, 2002), the blend is 50/50, and for FY 2003 (October 1, 2002 - September 30, 2003) the blend is 25/75.

If line 7.01 is greater than lines 6 and 7, enter the higher of lines 7 or 6 multiplied by the appropriate blend percentage. Add to this amount, the amount on line 7.01 multiplied by the appropriate FY 1996 HSR blend percentage. (42 CFR 412.92) If line 7.01 is not greater than lines 6 or 7, enter the greater of lines 6 or 7. If line 6 is greater than lines 7 and 7.01, enter that amount on this line.

Line 9--Enter the payment for inpatient program capital costs from Worksheet L, Part I, line 6; Part II, line 10; or Part III, line 5, as applicable.

Line 10--Enter the exception payment for inpatient program capital, if applicable, from Worksheet L, Part IV, line 13 for cost reporting periods beginning before October 1, 2001. For cost reporting periods beginning on and after October 1, 2001, if the provider continues to

qualify for the additional payment for extraordinary circumstances pursuant to 42 CFR 412.348(e) enter the exception payment for inpatient program capital from Worksheet L, Part IV, line 13. If the provider qualifies for the special exceptions payment pursuant to 42 CFR 412.348(g) enter the result of Worksheet L, Part IV, line 13 less Worksheet L, Part IV, line 17. If this amount is negative, enter zero on this line.

Line 11--Enter the amount from Worksheet E-3, Part IV, line 24. Complete this line only for the hospital component.

Obtain the payment amounts for lines 11.01 and 11.02 from your fiscal intermediary.

Line 11.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

Line 11.02--Enter the special add-on payment for new technologies (see change request 2301).

Line 12--Enter the net organ acquisition cost from Worksheet(s) D-6, Part III, column 1, line 61.

Line 13--Enter the cost of teaching physicians from Worksheet D-9, Part II, column 3, line 16.

Line 14--Enter on the appropriate Worksheet E, Part A, the routine service other pass through costs from Worksheet D, Part III, column 8, lines 25 through 30 for the hospital and line 31 for the subproviders.

Line 15--Enter the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 16--Enter the sum of lines 8 through 15.

Line 17--Enter the amounts paid or payable by workmens' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workmens' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, treat the services as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted by you in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 12. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 17 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductible and coinsurance on line 17.

Enter the primary payer amounts applicable to organ transplants. However, do not enter the primary payer amounts applicable to organ acquisitions. Report these amounts on Worksheet D-6, Part III, line 58.

If you are subject to PPS, include the covered days and charges in the program days and charges, and include the total days and charges in the total days and charges for inpatient and pass through cost apportionment. Furthermore, include the DRG amounts applicable to the patient stay on line 1. Enter the primary payer payment on line 17 to the extent that the primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter primary payer payments credited toward the beneficiary's deductibles.

Line 19--Enter from the PS&R or your records the deductibles billed to program patients.

Line 20--Enter from the PS&R or your records the coinsurance billed to program patients.

Line 21--Enter the program reimbursable bad debts, reduced by the bad debt recoveries. If recoveries exceed the current year's bad debts, line 21 and 21.01 will be negative.

Line 21.01--Enter line 21 (including negative amounts) times 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999, and 70 percent for October 1, 2000 and thereafter.

Line 21.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts must also be reported on line 21. (4/1/2004b)

Line 22--Enter the sum of lines 18 and 21.01 minus the sum of lines 19 and 20.

Line 23--Enter the programs share of any recovery of accelerated depreciation applicable to prior periods paid under reasonable cost or the hold harmless methodology under capital PPS resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136 - 136.16.)

Line 24--Enter any other adjustments. For example, enter an adjustment resulting from changing the recording of vacation pay from cash basis to accrual basis. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. Effective for discharges occurring on or after October 1, 2008, enter on line 24.98 the partial or full credits received from manufacturers for replaced devices applicable to MS-DRGs listed in Change Request 5860, transmittal 1509, dated May 9, 2008. Only FI/contractors complete line 24.99 by entering the sum of lines 52, 53, 55, and 56.

Line 25--If you are filing under the fully prospective payment methodology for capital costs or on the basis of 100 percent of the Federal rate under the hold harmless methodology, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. For providers paid under the hold harmless reasonable cost methodology, compute gains or losses on the disposal of old assets

in accordance with CMS Pub. 15-1, §§132-134.4. For gains or losses on new capital, enter the program's share of the gain or loss applicable to cost reimbursement periods for those assets purchased during a cost reporting period prior to the beginning of your first cost reporting period under capital PPS and disposed of in the current cost reporting period. For assets purchased and disposed of after the onset of capital PPS, make no adjustment. *(See 42 CFR 413.134(f)(1).)*

NOTE: Section 1861 (v) (1) (O) of the Act sets a limit on the valuation of a depreciable asset that may be recognized in establishing an appropriate allowance for depreciation, and for interest on capital indebtedness after a change of ownership that occurs on or after December 1, 1997, and restricts the gain or loss on the sale or scrapping of assets.

Enter the amount of any excess depreciation taken as a negative amount.

Line 26--Enter the amount due you (i.e., the sum of the amounts on line 22 plus or minus lines 24 and 25 minus line 23).

Line 27--Enter the sequestration adjustment amount, if applicable.

Line 28--Enter the total interim payments (received or receivable) from Worksheet E-1, column 2, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 28.01. Include in interim payment the amount received as the estimated nursing and allied health managed care payments.

Line 29--Enter line 26 minus the sum of lines 27 and 28. Transfer to Worksheet S, Part II.

Line 30--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

Lines 31 through 49 were intentionally skipped to accommodate future revisions to this worksheet.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART A. LINES 50 THROUGH 56 ARE FOR CONTRACTOR USE ONLY.

Line 50--Enter the original operating outlier amount from line 2.01 sum of all columns of this worksheet.

Line 51--Enter the original capital outlier amount from worksheet L, part I, line 3.01.

Line 52--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7

Line 53--Enter the capital outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7

Line 54--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 55--Enter the time value of money for operating related expenses line 52 times line 54.

Line 56--Enter the time value of money for capital related expenses line 53 times line 54.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 56, respectively, one time for each time the cost report is reopened.

3630.2 Part B - Medical and Other Health Services--Use Worksheet E, Part B, to calculate reimbursement settlement for hospitals, subproviders, and SNFs.

Use a separate copy of Worksheet E, Part B, for each of these reporting situations. If you have more than one hospital-based subprovider, complete a separate worksheet for each facility. Enter check marks in the appropriate spaces at the top of each page of Worksheet E to indicate the component program for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers. OPD PPS services furnished on or after 8/1/2000 is only applicable for hospital title XVIII providers. (See BBRA §202) For services rendered on or after August 1, 2000, for purposes of prospective payment for outpatient services, if the cost reporting periods overlap any of the effective dates, complete subscribed column 1.01 for lines 1.01 through 1.06 only and make a separate transitional corridor or geographic reclassification (urban to rural only) (42 CFR 412.103 and 412.230) payment calculation for the appropriate periods. This may result in multiple subscribed columns. Order the subscribed columns chronologically as the transition dates or geographic reclassification relate to your fiscal year. The dates should also agree with the format on Worksheet D, Part V, columns 9, 9.01, 9.02 and 9.03, etcetera

Line Descriptions

Line 1--Enter the cost of medical and other health services for title XVIII, Part B. This amount also includes the cost of ancillary services furnished to inpatients under the medical and other health services benefit of Medicare Part B. These services are covered in this manner for Medicare beneficiaries with Part B coverage only when Part A benefits are not available. Obtain this amount from Worksheet D, Part V, line 104, columns 9, 9.02 and 11, for hospitals and enter in column 1. Add to the amount reported in column 1 the amount from Worksheet D, VI, line 3 (and/or 3.01 as applicable) for services rendered through March 31, 2001 and on or after January 1, 2003. For SNFs transfer the amount from Worksheet D, Part V, column 9 plus Worksheet D, Part VI, lines 3. For RPCH/CAH providers electing the all-inclusive method of payment for outpatient services prior to October 1, 1997 (see Worksheet S-2, lines 30 through 30.02), obtain this amount from Worksheet C, Part V, column 7, line 108.

CAHs are not subject to transitional corridor payments, therefore lines 1.01 through 1.07 do not apply to CAHs. Transfer Worksheet D, Part V, column 9, line 104 and Worksheet D, Part VI, lines 3 and 3.01.

Line 1.01--Enter the medical and other health services for services rendered on or after August 1, 2000, from Worksheet D, Part V, column 9.01, line 104 added to the amount reported on Worksheet D, Part VI, line 3.01; line 3 for cost reporting periods beginning on or after April 1, 2001. Subtract from this amount outpatient pass through costs reported on Worksheet D, Part IV, line 101, columns 9 and subscripts as applicable.

Line 1.02--Enter the gross PPS payments received including payment for drugs, device pass through payments, and outliers.

Contractors only, add or subtract as applicable to the gross PPS payments the total outlier reconciliation amount from line 54.

Line 1.03--Enter the hospital specific payment to cost ratio provided by your intermediary. If a new provider does not file a full cost report for a cost reporting period that ends prior to January 1, 2001, the provider is not eligible for transitional corridor payments and should enter zero (0) on this line. (See PM A-01-51)

Line 1.04--Line 1.01 times line 1.03.

If line 1.02 is < line 1.04 complete lines 1.05 and 1.06. Otherwise do not complete lines 1.05 and 1.06.

Line 1.05--Line 1.02 divided by line 1.04.

Line 1.06--Enter the transitional corridor payment amount calculated based on the following: For purposes of determining the bed count for small rural hospitals see 42 CFR §412.105(b).

For cost services rendered from January 1, 2006 through December 31, 2008, calculate this line when the response to Worksheet S-2, line 21.06 is "Y".

For services rendered August 1, 2000, through December 31, 2001:

- a. Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is ≤ 100 , enter the difference of line 1.04 minus line 1.02; or
- b. Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- b. If line 1.05 is ≥ 90 percent but < 100 percent, enter 80 percent of (line 1.04 minus line 1.02).
- c. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 71 percent of (line 1.04) minus 70 percent of (line 1.02).
- d. If line 1.05 is ≥ 70 percent but < 80 percent, enter the result of 63 percent of (line 1.04) minus 60 percent of (line 1.02).
- e. If line 1.05 is < 70 percent, enter 21 percent of line 1.04.

For services rendered January 1, 2002, through December 31, 2002:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospital) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is ≤ 100 , enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the difference of line 1.04 minus line 1.02.

For all other hospitals enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 70 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is ≥ 80 percent but < 90 percent, enter the result of 61 percent of (line 1.04) minus 60 percent of (line 1.02).
- e. If line 1.05 is < 80 percent, enter 13 percent of line 1.04 .

For services rendered January 1, 2003, through December 31, 2003:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is ≤ 100 enter the result of line 1.04 minus line 1.02; or
- b. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For all other hospital enter one of the following:

- c. If line 1.05 is ≥ 90 percent but < 100 percent, enter 60 percent of the result of line 1.04 minus line 1.02.
- d. If line 1.05 is < 90 percent, enter 6 percent of line 1.04.

For services rendered on or after January 1, 2004 for cancer or children's hospitals only:

- a. If line 1.02 is $<$ line 1.04 and Worksheet S-2, line 19 response is 3 or 7 (cancer or children's hospitals), enter the result of line 1.04 minus line 1.02.

For services rendered January 1, 2004, through December 31, 2005, for small rural hospitals and small rural SCHs:

- a. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y" and Worksheet E, Part A, line 3 is ≤ 100 enter the result of line 1.04 minus line 1.02.
- b. If line 1.02 is $<$ line 1.04, Worksheet S-2, line 21 response is 2 (rural hospitals) or if 21.02 equals "Y", and Worksheet E, Part A, line 3 is ≤ 100 , and Worksheet S-2, line 26 is ≥ 1 (sole community hospitals (SCH)) enter the result of line 1.04 minus line 1.02.

For cost reporting periods beginning on or after January 1, 2004, through services rendered on or before December 31, 2005, for rural SCHs:

- a. If line 1.02 is $<$ line 1.04 or Worksheet S-2, line 26 response is ≥ 1 (number of periods SCH status in effect) enter the result of line 1.04 minus line 1.02.

NOTE: For purposes of TOPs, a hospital is considered rural if it is geographically rural, classified to rural for wage index purposes, or classified to rural for the standardized amount purposes. For example, a hospital that is geographically rural is always considered rural for TOPs, even if it is reclassified to urban for the wage index and/or standardized amount. A hospital that is geographically urban, but reclassified to rural for the wage index and/or standardized amount, is considered rural for purposes of TOPs.

In accordance with DRA 2005, section 5105, as amended by *MIPPA 2008, section 147*, for services rendered January 1, 2006, through *December 31, 2009*, rural hospitals with 100 or fewer beds that are not SCHs are entitled to hold harmless TOPs:

- a. For services rendered January 1, 2006, through December 31, 2006, if Worksheet S-2, line 21.06, is "Y", enter 95 percent of (line 1.04 minus line 1.02).
- b. For services rendered January 1, 2007, through December 31, 2007, if Worksheet S-2, line 21.06, is "Y", enter 90 percent of (line 1.04 minus line 1.02).
- c. For services rendered January 1, 2008, through *December 31, 2009*, if Worksheet S-2, line 21.06, is "Y", enter 85 percent of (line 1.04 minus line 1.02).

In accordance with MIPPA 2008, section 147, for services rendered January 1, 2009, through December 31, 2009, SCHs with 100 or fewer beds are entitled to hold harmless TOPs:

- a. For services rendered January 1, 2009, through December 31, 2009, if Worksheet S-2, line 21.07, is "Y", enter 85 percent of (line 1.04 minus line 1.02).*

Line 1.07--Enter the pass through amount from worksheet D, Part IV, columns 9, 9.01 and 9.02, line 101.

Line 2--Enter the cost of services rendered by interns and residents as follows from Worksheet D-2.

<u>Provider/Component</u>	<u>Title XVIII Hospital</u>	<u>Title XVIII Subprovider</u>	<u>Title XVIII Skilled</u>	<u>Nursing</u>
<u>Facility</u>				
Hospital	Part I, col. 9, line 9 plus line 24; or Part II, col. 7, line 34; or Part III, col. 6, line 41	Part I, col. 9, line 10; or Part II, col. 7, line 35, or Part III, col. 6, line 42	Part I, col. 9, line 12; or Part II, col. 7, line 37; or Part III, col. 6, line 44	

Line 3--If you are an approved CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 2, line 61 when Worksheet E is completed for the hospital or the hospital component of a health care complex. Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 4--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost (see 42 CFR 415.160 and CMS Pub. 15-I, §2148), enter the amount from Worksheet D-9, Part II, column 3, line 17.

Line 5--Enter the sum of lines 1 through 4 excluding subscripts in column 1.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

NOTE: RPCHs/CAHs are not subject to the computation of the lesser of reasonable costs or customary charges. If the component is an RPCH/CAH, do not complete lines 6 through 16. Instead, enter on line 17 the amount computed on line 5.

Line Descriptions

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter the total reasonable cost from line 5 directly on line 17. Still complete lines 6 through 16 to insure that you meet one of the criteria for this exemption.

Lines 6 through 10--These lines provide for the accumulation of charges which relate to the reasonable cost on line 5.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-I, §2104.3) and (2) charges to beneficiaries for excess costs. (See CMS Pub. 15-I, §§2570-2577.)

Line 6--For total charges for medical and other services, enter the sum of Worksheet D, Part V, columns 5 and 5.01 (for hospitals and subproviders with cost reporting periods which overlap October 1, 1997, for ambulance services, and SNFs with cost reporting periods beginning prior to January 1, 1998), line 104 and Worksheet D, Part VI, line 2. For cost reporting periods overlapping 8/1/2000 and after, for hospital and subprovider services, enter the sum of D, Part V, columns 5, 5.02, and 10, line 104, plus D, Part VI, line 2.

For cost reporting periods beginning 1/1/99 for SNF services enter the sum of Worksheet D, Part V, column 5, line 104 and D, Part VI, line 2.

payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less applicable deductible and coinsurance. Credit primary payer payment toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered charges in program charges, and include the charges in charges for cost apportionment purposes. Enter the primary payer payment on line 26 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Primary payer payments credited toward the beneficiary's deductible and coinsurance are not entered on line 26.

Line 25--Enter line 23 minus line 24.

Line 26--Enter the amount of reimbursable bad debts for deductibles and coinsurance for ESRD services reimbursed under the composite rate system from Worksheet I-5, line 9.

Line 27--Enter from your records reimbursable bad debts for deductibles and coinsurance net of recoveries for other services, excluding professional services. Do not include ESRD bad debts. These are reported on line 26. Bad debts associated with ambulance services rendered on or after April 1, 2002 (implementation of the cost/fee blend) are not allowable. If recoveries exceed the current year's bad debts, line 27 and 27.01 will be negative.

Line 27.01--Multiply the amount (including negative amounts) on line 27 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and thereafter (hospitals and subproviders only). The reduction does not apply to Critical Access Hospitals.

Line 27.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 27. (4/1/2004b)

Line 28--Enter the sum of lines 25, 26 and 27 or 27.01(hospitals and subproviders only).

Line 29--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 30--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. For cost reporting periods ending on or after June 30, 2006, enter on line 30.99 the MSP-LCC reconciliation amount. Obtain this amount from the PS&R.

Line 31--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.) Enter the amount of any excess depreciation taken as a negative amount in parentheses ().

Line 32--Enter the result of line 28, plus or minus lines 30 and 31 minus lines 29 and 30.99. Line 30.99 would only be included for cost reporting periods ending on or after June 30, 2006.

Line 33--Enter the sequestration adjustment amount, if applicable.

Line 34--Enter interim payments from Worksheet E-1, column 4, line 4. For intermediary final settlements, enter the amount reported on line 5.99 on line 34.01. For intermediary purposes it will be necessary to make a reclassification of the bi-weekly pass through payments from Part A

to Part B and report that Part B portion on line 34.01. Maintain the necessary documentation to support the amount of the reclassification.

Line 35--Enter line 32 minus the sum of lines 33 and 34. Transfer this amount to Worksheet S, Part II, column 3, line as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations for this line.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E, PART B. LINES 50 THROUGH 54 ARE FOR CONTRACTOR USE ONLY. (Effective for hospital outpatient services furnished during cost reporting periods beginning on or after January 1, 2009.)

Line 50--Enter the original outlier amount from line 4 sum of all columns of this worksheet.

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-4, Chapter 4, §10.7.2.2 - §10.7.2.4.)

Line 53-- Enter the time value of money by multiplying line 51 times line 52.

Line 54--Enter sum of lines 51 and 53.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

3630.3 Part C - Outpatient Ambulatory Surgical Center--Use this worksheet to calculate reimbursement settlement for outpatient ambulatory surgery for titles V, XVIII, and XIX for the hospital and/or subprovider for services rendered prior to August 1, 2000; otherwise do not complete.

NOTE: Rural primary care hospitals that have elected the all-inclusive method for payment of outpatient services (see Worksheet S-2, lines 30 through 30.02), and CAHs do not complete this worksheet.

As required by §§1833(a)(4), 1832(a)(2)(F), and 1833(I) of the Act, payment for facility services furnished in connection with covered ASC procedures furnished by hospitals on an outpatient basis is based on the lesser of the outpatient cost or charges (in the aggregate) net of cost sharing or a blend of hospital cost and ASC rates at 42/58. (See CMS Pub. 15-I, §2830.3.) For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, it is necessary to subscript the column to accommodate the change in payment methodology regarding the application of deductibles and coinsurance. For all cost reporting periods that begin on or after October 1, 1997, continue to use the subscripted column and no longer complete column 1.

Line Descriptions

Line 1--Enter the standard overhead amounts from the PS&R report or from your records. Payments to ASCs for covered procedures are made on the basis of prospectively set rates known as standard overhead amounts (ASC fees). (See CMS Pub. 15-I, §2830.3.)

Line 2--Enter in column 1 the deductibles billed to the program for services prior to October 1, 1997. For column 1.01, do not complete this line.

Line 3--Line 1 minus line 2.

Line 4--Enter 80 percent of line 3 in column 1. For column 1.01 do not complete this line.

Line 5--This amount is the ASC portion of the blended amount. The ASC portion of the blended amount is 58 percent of the amount on line 4 of column 1 and line 1 of column 1.01.

Line 6--Enter the amount of the outpatient ASC cost from Worksheet D, Part V, columns 6 and 6.01 (if applicable), line 104 in columns 1 (if applicable) and 1.01 respectively.

Computation of Lesser of Reasonable Cost or Customary Charges--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges for the same services for outpatient ambulatory surgical procedures only if that amount is lower than the blended ASC amount. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e).

If you bill an all-inclusive rate or bill gross departmental charges and reflect a discount on the bill, you must, when billing Medicare, show gross departmental charges for each service on the bill. Identify the difference between the sum of these gross charges and the net amount you wish to collect. Also maintain a memorandum record when you bill an all-inclusive charge to non-Medicare patients. Always use the gross departmental charges for cost apportionment purposes. Show the discount amount in the customary charge computations, as appropriate.

NOTE: If the medical and other health services reported here qualify for exemption from the application of LCC (see §3630), also enter total reasonable cost from line 6 directly on line 14. Still complete lines 8 through 13 to insure that you meet one of the criteria for this exemption.

Line 7--Enter the total charges which relate to reasonable cost on line 6 from Worksheet D, Part V, columns 2 and 2.01 (if applicable), line 104, in columns 1 (if applicable) and 1.01 respectively.

NOTE: If the amounts on Worksheet D, Part V, include charges for professional services, eliminate the amount of the professional component from the charges entered on line 7. Submit a schedule showing these computations with the cost report.

Lines 8 through 11--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most patients liable for payment for services on a charge basis) or fail to make reasonable efforts to collect such charges from those patients. If line 10 is greater than zero, multiply line 7 by line 10, and enter the result on line 11. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 8 through 10. Enter on line 11 the amount from line 7. In no instance may the customary charges on line 11 exceed the actual charges on line 7. (See 42 CFR 413.13(e).)

Line 12--Enter the excess of the customary charges over the reasonable cost. If line 11 exceeds line 6, enter the difference.

Line 1.08--Enter the net (blended) Federal IPF PPS payment for cost reporting periods beginning on or after January 1, 2005. This amount excludes payments for outliers, stop-loss, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 1.09--Enter the net (blended) IPF outlier payment. Obtain this from the PS&R and/or your records.

Line 1.10--Enter the net (blended) IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

NOTE: Complete only line 1.11 or line 1.12, but not both.

Line 1.11--For providers that trained residents *in the most recent cost reporting period filed before November 15, 2004* (response on Worksheet S-2, line 60.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

Line 1.12--For providers that did not train residents in the most recent cost *reporting period filed before* November 15, 2004, but qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to Worksheet S-2, line 60.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.13--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.14--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.15--For providers that completed line 1.11, enter the lower of the FTE count on line 1.13 or the cap amount on line 1.11.

For providers that qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) during the first 3 program years of the first new program's existence, enter the FTE count from line 1.14.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 1.13 or the FTE count on line 1.12. Add to this count the FTEs on line 1.14 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4th program year of the first new program.

Line 1.16--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.17--Enter the medical education adjustment factor by adding 1 to the ratio of line 1.15 to line 1.16. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as $\{(1 + (\text{line 1.15} / \text{line 1.16})) \text{ to the } .5150 \text{ power} - 1\}$.

Line 1.18--Enter the medical education adjustment by multiplying line 1.08 by line 1.17.

Line 1.19--Enter the adjusted net IPF PPS payments by entering the sum of lines 1.08, 1.09, 1.10, and 1.18.

Line 1.20--Enter the stop loss floor by entering the result of line 1 multiplied by 70 percent. For new IPFs (100 percent PPS) and for cost reporting periods beginning on or after January 1, 2008, enter zero (0) on this line.

Line 1.21--Enter the adjusted net payment floor by multiplying line 1.20 by the appropriate Federal blend payment percentage: (25 percent for cost reporting periods beginning on or after January 1, 2005 but prior to January 1, 2006, 50 percent for cost reporting periods beginning on or after January 1, 2006 but prior to January 1, 2007, or 75 percent for cost reporting periods beginning on or after January 1, 2007 but prior to January 1, 2008). Enter 100 percent if this is a new IPF (worksheet S-2, line 60, column 2 equals "Y") or for cost reporting periods beginning on or after January 1, 2008.

Line 1.22--If line 1.21 is greater than line 1.19 enter the amount on line 1.21 minus the amount on line 1.19; otherwise enter zero (0). This is the amount of the stop loss adjustment.

Line 1.23--Enter the IPF PPS payments by adding the amounts from lines 1.01, 1.19 and 1.22.

Inpatient Rehabilitation Facility (IRF)-Lines 1.35 through 1.42

In accordance with the Federal Register (see Vol. 70, No. 156, pages 47928-47932, dated August 15, 2005) and Change Request 4037 (CMS Pub. 100-04, transmittal 680 dated September 16, 2005), complete these lines for IRFs effective for discharges on or after October 1, 2005.

NOTE: Complete only line 1.35 or line 1.36, but not both.

Line 1.35--For providers that trained residents **in the most recent cost reporting period ending on or before November 15, 2004** (response to line 58.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

Line 1.36--For providers that did not train residents in the most recent cost *reporting period* ending on or before November 15, 2004, that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to line 58.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.37--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.38--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.39--For providers that completed line 1.35, enter the lower of the FTE count on line 1.37 or the cap amount on line 1.35.

For providers that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005), during the first 3 program years of the first new program's existence enter the

Line 16--Enter line 10 less line 13. This is the physical therapy indirect cost for the entire reporting unit.

Line 17--Enter line 11 less line 14. This is the occupational therapy indirect cost for the entire reporting unit.

Line 18--Enter line 12 less line 15. This is the speech therapy indirect cost for the entire reporting unit.

Line 19--Enter the charge to charge ratio for physical therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 50 by the amount on Worksheet C, Part I, column 8, line 50.

Line 20--Enter the charge to charge ratio for occupational therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 51 by the amount on Worksheet C, Part I, column 8, line 51.

Line 21--Enter the charge to charge ratio for speech therapy. To obtain this figure, divide the amount on Worksheet D-4, column 2, line 52 by the amount on Worksheet C, Part I, column 8, line 52.

Line 22--Calculate the physical therapy demonstration indirect cost by multiplying line 16 by line 19.

Line 23--Calculate the occupational therapy demonstration indirect cost by multiplying line 17 by line 20.

Line 24--Calculate the speech therapy demonstration indirect cost by multiplying line 18 by line 21.

Line 25--Enter the sum of lines 6, 9, 22, 23, and 24. Transfer this amount to Worksheet E-3, Part III, line 24.

3633.6 Part VI – Direct GME and IME Payments related to MMA section 422 (Public Law 108-173) “Redistribution of Unused Residency Slots”--Use this worksheet in conjunction with Worksheet E-3, Part IV and Worksheet E, Part A to calculate payment for direct GME as determined under 42 CFR 413.75 through 413.83 and IME as determined under 42 CFR 412.105 for hospitals that received an adjustment (reduction or increase) to their FTE resident caps for direct GME and/or IME under Section 422 of Public Law 108-173. Do not use this worksheet if the cost reporting period ends prior to July 1, 2005 or if the cost reporting period ends after July 1, 2005 but the hospital did not receive an adjustment to either the GME or IME cap under Section 422 of Public Law 108-173.

Line 1--Enter the ratio of the number of days from July 1, 2005 to the end of the cost reporting period divided by the total number of days in the cost reporting period. For example, for a cost reporting period of October 1, 2004 to September 30, 2005, enter .252055 (i.e., 92 days from July 1, 2005 to September 30, 2005 divided by 365 days in the cost reporting period). For cost reporting periods which do not overlap July 1, 2005, enter 1 on this line.

Lines 2-4 --Computation of reduced direct GME cap under 42 CFR §413.79(c)(3). Complete lines 2 through 4, only where Worksheet S-2, line 25.05, column 1, is “Y”.

Line 2--Reduced Direct GME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced direct GME cap as specified under 42 CFR §413.79(c)(3). However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.

Line 3--Unadjusted Direct GME FTE Cap. Enter the unadjusted direct GME FTE Cap from

Worksheet E-3, Part IV, sum of lines 3.01 and 3.02.

Line 4 --For cost reporting periods that overlap July 1, 2005, enter the ratio on line 1 multiplied by the count on line 2. Add to this count the count on line 3 multiplied by the result of "1" minus line 1. This is the prorated cap for that fiscal year. For cost reporting periods beginning on or after July 1, 2005, enter the count on line 2. This is the hospital's reduced direct GME FTE cap.

Lines 5-12--Computation of additional direct GME payments for unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 CFR §413.79(c)(4). Complete lines 5 through 12, only where Worksheet S-2, line 25.06, column 1, is "Y".

Line 5--Section 422 Direct GME FTE Cap. Enter the number of unweighted allopathic and osteopathic direct GME FTE resident cap slots the hospital received under 42 CFR §413.79(c)(4).

Line 5.01--Prorated Direct GME FTE Cap. For cost reporting periods that overlap July 1, 2005, enter the result of multiplying the ratio on line 1 by the number on line 5 in order to establish the cap for the portion of the cost reporting period occurring after July 1, 2005. Use this line only when the cost reporting period overlaps July 1, 2005.

Line 6--Direct GME FTE Resident Count Over the Cap: Subtract line *3.06* on Worksheet E-3, Part IV from line *3.05* on Worksheet E-3, Part IV and enter the result here. If the result is zero or negative, the hospital does not need to use the direct GME 422 cap and lines 7 through 12 *do not need to be* completed.

Line 7--Section 422 Allowable Direct GME FTE Resident Count: If the count on line 6 is greater than the count on line 5, *divide line 3.09 of Worksheet E-3, Part IV by line 3.05 of Worksheet E-3, Part IV, and multiply the resulting ratio by the amount on line 5 of this worksheet.* If the count on line 6 is less than or equal to the count on line 5, *divide line 3.09 of Worksheet E-3, Part IV by line 3.05 of Worksheet E-3, Part IV, and multiply the resulting ratio by the amount on line 6 of this worksheet.* For cost reporting periods that overlap the July 1, 2005 effective date, substitute line 5.01 for line 5, in the calculation of line 7.

Line 8--Enter the locality adjusted national average per resident amount as specified at 42 CFR section 413.77(g), inflated to the hospital's cost reporting period.

Line 9--Enter the product of Line 7 and Line 8. This is the allowable section 422 GME cost.

Line 10--Enter the Medicare program patient load from Line 6 of Worksheet E-3, Part IV.

Line 11--Enter the product of line 9 and line 10. This is the section 422 direct GME payment for non-managed care days.

Line 12--Determine the direct GME payment for managed care days by multiplying line 9 by the managed care patient load computed from worksheet E-3, Part IV: [(line 6.02 + line 6.06)/line 5]. Reduce this amount by the Nursing Allied Health Medicare advantage factor. (See Worksheet E-3, Part IV, line 6.08).

Lines 13-15--Computation of reduced IME cap under 42 CFR §412.105(f)(1)(iv)(B). Complete lines 13 through 15, only where Worksheet S-2, line 25.05, column 2, is "Y".

Line 13--Reduced IME FTE Cap. Effective for cost reporting periods ending on or after July 1, 2005, enter the reduced IME FTE resident cap for allopathic and osteopathic residents as specified under 42 CFR §412.105(f)(1)(iv)(B). However, if the resulting reduced direct GME cap is less than zero (0), enter zero on this line.

3659. WORKSHEET J-4 - ANALYSIS OF PAYMENTS TO HOSPITAL-BASED
OUTPATIENT REHABILITATION PROVIDER FOR SERVICES RENDERED TO
PROGRAM BENEFICIARIES

Complete this worksheet for Medicare interim payments only. If you have more than one hospital-based outpatient rehabilitation provider, complete a separate worksheet for each facility.

Complete the identifying information on lines 1 through 4. The remainder of the worksheet is completed by your fiscal intermediary.

Line Descriptions

Line 1--Enter the total program interim payments paid to the outpatient rehabilitation provider. The amount entered reflects the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. The amount entered includes amounts withheld from the component's interim payments due to an offset against overpayments to the component applicable to prior cost reporting periods. It does not include any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, or tentative or net settlement amounts, nor does it include interim payments payable.

Line 2--Enter the total program interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period, but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4--Transfer the total interim payments to the title XVIII Worksheet J-3, line 27.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET J-4. LINES 5 THROUGH 7 ARE FOR INTERMEDIARY USE ONLY.

Line 5--List separately each tentative settlement payment after desk review together with the date of payment. If the cost report is reopened after the Notice of Program Reimbursement (NPR) has been issued, report all settlement payments prior to the current reopening settlement on line 5.

Line 6--Enter the net settlement amount (balance due to the provider or balance due to the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening.

NOTE: On lines 3, 5, and 6, when an amount is due from the provider to the program, show the amount and date on which the provider agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

Line 7--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. The amount in column 2 must equal the amount on Worksheet J-3, line 26.

3660. WORKSHEET L - CALCULATION OF CAPITAL PAYMENT

Worksheet L, Parts I through IV, calculate program settlement for PPS inpatient hospital capital-related costs in accordance with the final rule for payment of capital-related costs on a prospective payment system pursuant to 42 CFR 412, Subpart M. (See the August 30, 1991 **Federal Register**.) Only provider components paid under PPS complete this worksheet.

Worksheet L consists of the following four parts:

- Part I - Fully Prospective Method
- Part II - Hold Harmless Method
- Part III - Payment Under Reasonable Cost
- Part IV - Computation of Exception Payments

COMPLETE ONLY PART I, II, OR III.

At the top of the worksheet, indicate by checking the applicable boxes the health care program, provider component, and the PPS capital payment method for which the worksheet is prepared.

3660.1 Part I - Fully Prospective Method--This part computes settlement under the fully prospective method only, as defined in 42 CFR 412.340. Use the fully prospective method for PPS capital settlement when the hospital's base year hospital-specific rate is below the adjusted Federal rate.

Line Descriptions

Line 1--Enter the amount of the hospital-specific rate portion of capital payments for discharges during the period. Do not complete this line for cost reporting periods beginning on and after October 1, 2001 for hospitals paid 100 percent of the Federal rate.

Line 2--Enter the amount of the Federal rate portion of the capital DRG payments for other than outlier during the period. Subscript column 1 as indicated in the general instructions for lines 4.02 through 4.03.

Line 3--Enter the amount of the Federal rate portion of the capital outlier payments made for PPS discharges during the period. (See 42 CFR 412.312(c).) Subscript this line to report outlier payments received for services rendered before October 1, 1997, and on or after October 1, 1997.

Line 4--Enter the result of dividing the sum of total patient days (Worksheet S-3, Part I, column 6, lines 12 and 28) by the number of days in the cost reporting period (365 or 366 in case of leap year). Do not include statistics associated with an excluded unit (subprovider).

NOTE: Reduce total patient days by nursery days (Worksheet S-3, Part I, column 6, line 11), and swing bed days (Worksheet S-3, Part I, column 6, lines 3 and 4).

Line 4.01--Enter the number of interns and residents from Worksheet S-3, Part I, column 9, line 12. For cost reporting periods beginning on or after October 1, 1997 obtain the intern and resident amount from Worksheet E, Part A, line 3.17. In addition, for cost reporting periods beginning on or after July 1, 2005, if the hospital received additional IME FTE resident cap slots under 42 CFR §413.79(c)(4) (Worksheet S-2, line 25.06, column 2, is "Y") add the amount reported on Worksheet E-3, Part VI, line 18). For cost reporting periods that overlap July 1, 2005, multiply the FTE count from Worksheet E-3, Part VI, line 18 by line 1 in order to prorate the number of days in the cost reporting period occurring after July 1, 2005.

Lines 4.02 through 4.03--IME Adjustment Factor Phase Out--In accordance with 42 CFR 412.322(c) and (d), the IME adjustment factor is eliminated for discharges occurring on or after 10/1/2009. Consequently, for line 2 (above) and lines 4.02 through 4.03, column 1 must be subscripted to accommodate the corresponding portion of the provider's cost reporting period when the provider's cost reporting period overlaps 10/1/2009. For cost reporting periods beginning on or after 10/1/2009, do not subscript column 1.

Line 4.02--Enter the result of the following calculation: $\{e^{.2822 \times \text{line 4.01}/\text{line 4}}\}-1$ where $e = 2.71828$. (See 42 CFR 412.322(a)(3) for limitation of the percentage of I&Rs to average daily census. Line 4.01 divided by line 4 cannot exceed 1.5. *The capital IME adjustment factor is not applicable beginning 10/1/2009, therefore enter -0- on this line for discharges occurring on or after 10/1/2009.*

Line 4.03--Multiply line 4.02 by the sum of lines 2 and 3. Do not include line 3.01.

Lines 5 - 5.04

NOTE: Enter the amount of the Federal rate portion of the additional capital payment amounts relating to the disproportionate share adjustment. Complete these lines if you answered yes to line 36.01 on Worksheet S-2. (See 42 CFR 412.312(b)(3).) For hospitals qualifying for disproportionate share in accordance with 42 CFR 412.106(c)(2) (Pickle amendment hospitals), do not complete lines 5 through 5.02, and enter 11.89 percent on line 5.03.

Line 5--Enter the percentage of SSI recipient patient days (from your intermediary or your records) to Medicare Part A patient days. This amount agrees with the amount reported on Worksheet E, Part A, line 4.

Line 5.01--Enter the percentage resulting from the calculation of Medicaid patient days (Worksheet S-3, Part I, column 5, line 12, plus line 2, minus the sum of lines 3 and 4) divided by total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4. Increase total patient days by any employee discount days reported on Worksheet S-3, Part I, line 28.

For cost reporting periods beginning on or after October 1, 2004, enter the percentage resulting from the calculation of the total Medicaid patient days (Worksheet S-3, Part I, column 5, line 12 plus line 2, minus the sum of lines 3 and 4, plus column 5.01, line 26) to total days reported on Worksheet S-3, column 6, line 12, minus the sum of lines 3 and 4, plus column 6.01, line 26. Increase total days by any employee discount days reported on worksheet S-3, Part I, column 6, line 28.

Line 5.02--Add lines 5 and 5.01, and enter the result.

Line 5.03--Enter the percentage that results from the following calculation: $(e^{.2025 \times \text{line 5.02}})-1$ where e equals 2.71828.

Line 5.04--Multiply line 5.03 by the sum of lines 2 and 3 (do not include line 3.01), and enter the result.

Line 6--Enter the sum of lines 1, 2 (and subscripted columns), 3, 3.01, 4.03 (and subscripted columns), and 5.04. For title XVIII, transfer the amount on line 6 to Worksheet E, Part A, line 9. For titles V and XIX, transfer this amount to Worksheet E-3, Part III, column 1, line 26.

3660.2 Part II - Hold Harmless Method.--This part computes settlement under the hold harmless method only as defined in 42 CFR 412.344. Use the hold harmless method for PPS capital settlement when the hospital's base year hospital-specific rate exceeds the established Federal rate. Do not complete this part for cost reporting periods beginning on and after October 1, 2001, except for new providers certified prior to October 1, 1999, that are paid in accordance with 42 CFR 412.324(b)(3). Formerly hold harmless providers (other than new providers) should consider themselves fully prospective and complete Part I of the Worksheet.

This part (Worksheet L, Part II) is no longer applicable for cost reporting periods beginning on or after October 1, 2008.

NOTE: If you have elected payments at 100 percent of the Federal rate (as indicated on Worksheet S-2, line 37.01), complete only lines 5 and 10 of this part.

Line Descriptions

Line 1--Enter the amount of program inpatient new capital costs. This amount is the sum of the program inpatient routine service new capital costs from the appropriate Worksheet D, Part I, column 12, sum of lines 25 through 30 and 33 for the hospital and line 31 for the subproviders and program inpatient ancillary service new capital costs from Worksheet D, Part II, column 8, line 101.

Line 2--Enter the amount of program inpatient old capital costs. This amount is the sum of the program inpatient routine service old capital costs from the appropriate Worksheet D, Part I, column 10, sum of lines 25 through 30 and 33 for the hospital and line 31 for the subproviders and program inpatient ancillary service old capital costs from Worksheet D, Part II, column 6, line 101.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the ratio of new capital costs on line 1 to the total capital cost on line 3. Carry the ratio to six decimal places.